MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR 2016

WEDNESDAY, MARCH 4, 2016.

DEPARTMENT OF VETERANS AFFAIRS

WITNESS

ROBERT A. MCDONALD, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

ACCOMPANIED BY:

DR. CAROLYN M. CLANCY, INTERIM UNDER SECRETARY FOR HEALTH

ALLISON A. HICKEY, UNDER SECRETARY FOR BENEFITS

STEPHEN W. WARREN, EXECUTIVE IN CHARGE FOR INFORMATION AND TECHNOLOGY

HELEN TIERNEY, EXECUTIVE IN CHARGE FOR THE OFFICE OF MANAGEMENT AND CHIEF FINANCIAL OFFICER

GLENN R. POWERS, DEPUTY UNDER SECRETARY FOR FIELD PROGRAMS

CHAIRMAN OPENING STATEMENT

Mr. DENT [presiding]. Good morning.

I would like to bring to order this hearing for Veterans Affairs—for the MILCON V.A. Subcommittee. Thank you all for attending.

And today, I am very pleased to welcome Secretary Robert A. McDonald, Secretary of the Department of Veterans Affairs, for his first appearance before this subcommittee, defending his fiscal year 2016 budget request.

Mr. Secretary, we know you have a lot of important material you want to present to us today, and subcommittee members have a lot of questions for you and I know competing hearings as well. So we would appreciate you being willing to keep your opening remarks to within 10 minutes.

I will also keep my opening remarks to a minimum.

Secretary Bob, you come before us at a challenging time for the V.A. You are trying to recover from the wait list scandal and implement the complex new Choice legislation.

And you are trying to bring about a transformation of the agency to make it more veteran-service-centric and certainly more customer-friendly, and we appreciate those very good and sincere efforts.

You are also defending an enormous budget increase in your discretionary budget of about $5.1 billion, or a 7.8 percent increase,

which is financed by offsets in the President's budget that Congress, frankly, is unlikely to accept.

I have to be frank with you, Mr. Secretary. Any increases are going to be extremely difficult to fund under the constraints we have, and all departments are going to be affected under the BCA, the Budget Control Act, with a government-wide increase in the non-defense discretionary cap of $1.1 billion. We can't make room for a $5.1 billion increase without taking a machete to important programs in other subcommittees. I suspect the chairman may agree with me on that point.

We fully appreciate the complex mission you have at the V.A. and share your dedication to making it work better. You have a lot of great employees out there, and when I visit facilities, I am always extraordinarily impressed by your medical team and all the allied health professionals.

The subcommittee welcomes the opportunity to learn about your vision for addressing the V.A.'s problems and reforming the agency so that we are sure we are giving veterans who want to use the V.A. the services they deserve.

Mr. Bishop is not here at the moment.

I am going to quickly yield to the chairman and then to the ranking member of the full committee for their opening statements.

FULL COMMITTEE CHAIRMAN OPENING STATEMENT

Mr. ROGERS. Thank you, Mr. Chairman, and congratulations, by the way, on assuming this chair.

Mr. DENT. Thank you.

Mr. ROGERS. This is your first hearing?

Mr. DENT. Third hearing.

Mr. ROGERS. Third hearing? Well, Okay. You are off to a good start.

Anyway, congratulations to you, and best wishes.

Mr. Secretary, we are glad to have you here.

You have ranked some very impressive credentials to this job from the private sector, and we are looking for great things from you and your staff. You've got your headaches, you've got your problems, but I feel like you are the man for the job. We congratulate and welcome you to this subcommittee for your first time.

The V.A. is charged with carrying out an essential responsibility of the U.S. government, and that is ensuring the health and well-being of our nation's vets, who selflessly serve with dignity and honor.

This charge brings a host of challenges: providing our veterans with timely access to quality health care, ensuring that they receive appropriate compensation for disabilities, and fighting the persistent problems of veterans' homelessness and substance abuse.

Just last summer, we were made aware of gross mismanagement and negligence on the part of this department. Veterans were kept on wait lists for months, awaiting health care services and treatments that they have been guaranteed by their government and deservedly so.

We can all agree that treating our veterans this way is unacceptable, and I commend you for your willingness to face these serious issues head on and the actions you have taken to right the ship.

Among the changes you have made to the V.A. care model is the implementation of the Veterans Choice program. The Choice program has offered thousands of veterans the opportunity to get off lengthy wait lists and seek treatment outside of the V.A. health care system.

We are beginning to see progress on the wait lists, and veterans now have access to health care facilities closer to their homes. But even with this progress, more work remains.

Many veterans who should qualify for the Choice program have been denied access by the V.A. These veterans either live more than 40 miles from a V.A. facility or must drive distances in excess of 40 miles to reach one due to geographical impediments.

This department must take steps to ensure that the 40-mile rule and qualifying exceptions are applied evenly and in a timely manner.

While we continue to hone and improve new programs, such as Veterans Choice, it is critical that V.A. does not lose sight of important modernization initiatives that Congress has been promoting for years.

One such initiative is digitizing V.A.'s medical records.

Mr. Secretary, your budget includes $141 million for scanning files and medical records into digital format, which is the same as your fiscal 2015 allocation.

For 2015, the committee provided an additional $40 million for three specific purposes—regional-office staffing, digitized scanning and the centralized-mail initiative—yet you have only allocated $10 million of that for scanning and centralized mail.

Eliminating the need to locate and transfer paper records will streamline the claim and benefit process tremendously. We need a strong commitment from the department to make this a reality.

I have visited one such center and noticed the huge bundles in a file, bound maybe this thick—paper, that is shipped all around the country trying to find its place.

You are digitizing those records, which means you can electronically, instantaneously access that file without having to ship it from Burbank, California. So I really hope that we can see more of this.

Another initiative Congress has been emphasizing for some time now is the implementation of the electronic health-record system that is interoperable with the DOD system.

Your budget requests $233 million for the V.A. electronic health record and sets aside $50 million of that for achieving the interoperable capacity.

I appreciate your commitment to that initiative in the budget and the work you have done to stand up a framework that will allow your record system to work with DOD's. And you have all heard me talk about this one instance a few years ago. A vet from my district was injured by a bomb in Iraq, and he lost one eye. The other eye was severely injured.

Then he was discharged, and the eye begins to act up. So he goes to the V.A. hospital in Lexington, and V.A. declines to treat him.

They were afraid to operate not knowing what had happened in the DOD hospital in Germany, and they couldn't get the records.

So he lost his other eye simply because of the incapability of these two bureaucratic agencies to work together. That is going to stop, and you are making a really good start, and I appreciate that very much.

I continue to be concerned that until DOD awards a contract to produce its record and V.A. shows demonstrable progress with modernization of its record, we can't be sure that this goal will be achieved in the near term.

I can't emphasize strongly enough the importance of achieving interoperability with DOD's electronic health-record system. If these two systems can't talk to each other, which I find incomprehensible, we continue to run the risk of service members receiving inadequate care and undergoing inadvisable procedures.

We need more than words on this critical issue; we need results. In fact, we are demanding results.

We had a meeting less than a year ago with the Secretary of Defense, and the Secretary of V.A., and we talked about this extensively. Both sides agreed to work it out. But both sides are protecting their own turf.

And so you will find language in your appropriations that puts you under the gun on this, and we are going to do the same with the DOD, which we have been doing for several years.

And finally, let me stress to you the seriousness of the problem of prescription-drug abuse among our vets.

We have all seen in the news the V.A. hospital in Tomah, Wisconsin that some are referring to as "Candy Land." We now know that officials there have been overprescribing opioids and possibly even contributing to the abuse of these drugs by our veterans.

I am pleased to see that the V.A. Office of Inspector General is investigating that case. It is my hope that this investigation will lead to safer practices among those treating patients suffering from drug addiction.

This committee is also interested to know what other actions the department is taking, regarding these disturbing developments in Wisconsin, and I hope you touch on that today.

As part of your opioid-safety initiative, it is important that the V.A. continue to pursue alternative remedies to prescription opioids and consider new technology such as abuse-deterrent drug formulations and tamper-resistant packaging.

It is also critical that we continue to invest in tried and true models like veterans treatment courts. These courts which require regular court appearances, drug testing and treatment sessions are integral to helping our veterans find a way forward and out of addiction.

This committee stands ready and willing to tackle these issues with you head on, and we hope that your department will remain a committed partner in the fight against prescription drugs, which the Center for Disease Control now says is a national epidemic.

We look forward to learning how you plan to offer more timely and accessible health care to our vets and fulfill the promise that both Congress and the V.A. have made to serve them.

Thank you.

I have to go to another couple of hearings. I am going to miss part of your testimony, which I regret.

Mr. Chairman, thank you.

Mr. DENT. Thank you, Mr. Chairman.

I want to second your statement, particularly the issue of the interoperability between the V.A. and the DOD health record. It is very important. It is a priority, I think, for all of us.

At this time, I would like to recognize distinguished ranking member, Mrs. Lowey.

FULL COMMITTEE RANKING MEMBER OPENING STATEMENT

Mrs. LOWEY. I too would like to thank my friend, Chairman Dent. Congratulations.

And unfortunately, Ranking Member Bishop, who has worked on these issues for a long time, I know he has worked with you, he couldn't be here today.

But this is a very important hearing, and I would like to welcome Secretary McDonald and your assistants and all of our distinguished guests this afternoon.

As the subcommittee reviews the fiscal year 2016 President's budget request, we have the tough mission and responsibility to ensure the funding of the Department of Veterans Affairs adequately addresses some very serious issues.

The number of current veterans and those transitioning into the V.A. health care system is staggering. We must ensure that we have the right programs and services these men and women deserve for their service to our nation. We made certain promises to our veterans. We are obligated to deliver.

In your short time, Mr. Secretary, your efforts have led to reductions in the claims backlog, accountability in your workforce and initiation of several new programs to meet the growing demand and concern of all veterans.

Specifically, I applaud the use of technology in the V.A. to further automate the claims submission and approval process, which I understand has reduced the overall wait time by 138 days for a decision.

And I just want to say, the chairman and I have been so frustrated. We have had four hearings. A couple of public hearings, a couple of closed door hearings. It is beyond me, frankly, that you can't get this done. And I know you are working towards that end. I won't put up pictures of all the old files that were kept in boxes. But it is such a disservice to the men and women who served our country with such distinction. Frankly, I still can't understand that the people who send our young men and women in harm's way, our government, can't get this done. But I am glad you are working on it, I am glad there is progress.

It is amazing to me, in the private sector, you leave a job, you take the chip, bring your health care information to the next employer, and we are still going through boxes. But thank you for the progress that has been made.

And I look forward to the day, Mr. Chairman, and Mr. Big Chairman, when we can hear "mission accomplished," and that it would be completed. Because we know there is so much more work to be done.

At last count, by the way, the claims backlog was still around 214,000. And then there are more claims that are continuously added into the system.

I hope you move this process forward expeditiously.

I am also very concerned about the amount of qualified medical personnel necessary to address the increasing number of veterans in serious issues like mental illness, post traumatic stress disorder, traumatic brain injury, and suicide prevention, especially in remote areas where there are limited or no V.A. facilities.

I know we are in a fiscally uncertain environment. The Budget Control Act remains. There may be some impact to certain services in programs where veterans are a top priority. And while there is cause to celebrate some successes, we can and must do better. We are committed to working with you going forward.

And I think it is important, Mr. Chairman, and I know the chairman is struggling with the numbers, and we don't know exactly the numbers that we are dealing with but I think it is important when the numbers are released and we get an analysis of what those numbers will do to the whole process.

So, Mr. Secretary, again, welcome. I, too, want to apologize, because we have about four hearings today. But I look forward to continuing to talk with you, working with you. And I just want to say in closing and expedite that process—I am glad to know that you have new facilities for records, but I still can't understand why it is taking so long.

Thank you very much for the progress you have made and thank you for your service.

Mr. DENT. Thank you, Mrs. Lowey, for your comments.

At this time, Mr. Secretary, your full statement will be included in the official record. After you introduce those who are accompanying you today, please feel free to begin.

And members are reminded that we will be operating on a 5-minute rule for questions. So, with that, Secretary Bob.

SECRETARY'S OPENING STATEMENT

Mr. MCDONALD. Thank you. Thank you, Mr. Chairman.

I have with me today Under Secretary Hickey and Under Secretary Clancy, who will join me, as well as our CFO, Helen Tierney and Steph Warren, who runs our I.T. operation. And hopefully, we will get a chance to get into detail on some of the issues that you all raised, like the electronic health record.

Chairman Rogers, Chairman Dent, Ranking Member Lowey, Ranking Member Bishop, members of the subcommittee, thanks for the opportunity to discuss the 2016 budget and 2017 Advanced Appropriations request.

I appreciate the opportunity to speak with many of you prior to this hearing. We deeply appreciate Congress' and the President's steadfast support for veterans, their families, and survivors, as well as the assistance of veterans service organizations.

As V.A. emerges from one of the most serious crises the department has ever experienced, we have before us a critical opportunity to improve care for veterans, and to build a more effective system. With your support, the V.A. intends to take full advantage of this opportunity.

Members of this Committee and VSOs share my goal to make the V.A. a model agency with respect to customer experience, an example for other government agencies. With efficient and effective operations, we look to be comparable to the top private sector businesses.

The cost of fulfilling our obligations to veterans rose over time because veterans' demands for services and benefits continue to increase as wars end.

In 2014, 22 percent of Vietnam veterans were receiving service-connected disability benefits. That is four decades after the war ended. We expect the percentage will continue to increase. And it is worth remembering that today, almost 150 years after the Civil War, V.A. is still providing benefits to the child of a Civil War veteran.

We still have troops in both Afghanistan and Iraq. Yet, in the last decade, we have already seen dramatic increases for demand for benefits and care.

From 1960 to 2000, the percentage of veterans receiving V.A. compensation was stable at about 8.5 percent. But in just 14 years, since 2001, the percentage dramatically increased to 19 percent, more than double.

Simultaneously, the number of claims and medical issues in claims has soared. In 2009, VBA completed almost 980,000 claims. In 2017, we project we will complete over 1.4 million claims. That is a 47 percent increase.

But there has been more dramatic growth in the number of medical issues in every single claim; 2.7 million in 2009 and a projected 5.9 million in 2017. That is a 115 percent increase over just 8 years.

These increases were accompanied by a dramatic rise in the average degree of veterans' disability compensation. For 45 years, from 1950 to 1995, the average period of disability was 30 percent. Since 2000, the average period of disability has risen to 47.7 percent.

So, while it is true that the total number of veterans is declining, the number of those seeking care and benefits is increasing dramatically. Fueled by more than a decade of war, Agent Orange-related claims, an unlimited claims appeal process, increased medical claims issues, far greater survival rates for those wounded on the battlefield, more sophisticated methods for identifying and treating veterans' medical issues, and importantly, the demographic shifts—our veterans are aging, veterans' demands for services and benefits exceeded V.A.'s capacity to meet them. It is important that Congress and the American people understand why that is happening.

The most important consideration is that American veterans are aging and retiring. Just 40 years ago, only 2.2 million veterans were 65 years old or older. That is 7.5 percent of the population. In 2017, we expect 9.8 million veterans will be 65 years or older. That is 46 percent of all veterans.

We now serve an older population with a greater demand for care, more chronic conditions, less able to afford private sector care. Currently, 11 million of the 22 million veterans in this country are registered, enrolled, or use at least one V.A. benefit or service. More are demanding V.A. services and care than ever before.

Requirements for women veterans and mental health care have increased dramatically. Over 635,000 women veterans are now enrolled for health care. And over 400,000 actively use V.A. That is double the number in the year 2000.

Annual increases in women veterans seeking care, about 9 percent. And this trend will continue.

Our women veteran call center now connects with over 100,000 women veterans per year.

In 2014, over 1.4 million veterans with a mental health diagnosis entered VHA. And we had 19.6 million mental health outpatient encounters. That is an increase of 64 percent and 72 percent, respectively, since only 2005.

Since its inception in 2007, our veterans' crisis line has answered over 1.6 million calls, and assisted in over 45,000 rescues. As veterans witness the positive changes V.A. is making, and as the military downsizes, the number of veterans choosing V.A. services will continue to rise. It should, and they have earned it.

We are listening hard to what veterans, Congress, employees and veterans service organizations are telling us. What we hear drives us to a historic department-wide transformation, changing V.A.'s culture and making veterans the center of everything we do.

We call it MyVA, and it entails many organizational reforms to better unify the department's efforts on behalf of veterans. MyVA focuses on five objectives to revolutionize culture and reorient V.A. on veterans' outcomes, rather than internal metrics.

First is improving the veteran experience so that every veteran has a seamless, integrated and responsive customer service experience every single time.

Second, improving the employee experience by eliminating barriers to customer service and focusing on our people and our culture so that we can better serve veterans.

Third, improving our internal support services.

Fourth, establishing a culture of continuous improvement to identify and correct problems faster and replicate solutions at all facilities.

And last, enhancing strategic partnerships. The American people, many partners want to join us in this effort, and we welcome them inside the tent.

MyVA is reorganizing the department geographically and that's the first substantial step in achieving this goal. In the past, V.A. had nine disjointed geographic organizational structures, one for each one of our nine lines of business. Our new unified organizational framework has one national structure, which is five regions.

This aligns V.A.'s disparate organizational boundaries into a single framework. This facilitates internal coordination and collaboration among our business lines, creates opportunities for local level integration, and promotes effective customer service. Veterans will see one V.A. rather than individual disconnected organizations.

Last, MyVA is also about ensuring sound stewardship of taxpayer dollars. We will integrate management improvement systems, such as Lean Six Sigma, across operations to ensure we balance veteran-centric service with operational efficiency.

But we need the help of Congress. V.A. cannot be a sound steward of the taxpayers' resources with the asset portfolio we carry. No business would carry such a portfolio, and veterans deserve better.

It is time to close V.A.'s old substandard and underutilized infrastructure. Nine hundred V.A. facilities are over 90 years old, and more than 1,300 are over 70 years old. V.A. currently has 336 buildings that are vacant, or less than 50 percent occupied.

That is 10.5 million square feet of excess space costing an estimated $24 million annually to maintain. These funds could be used to hire roughly 200 registered nurses for a year, pay for 144,000 primary care visits for veterans, or support 41,900 days of nursing home care for veterans in community living centers.

We need your support to do the right thing. MyVA reforms will take time, but over the long term they will enable us to better provide veterans with services and benefits they have earned, and that our nation has promised them.

Our 2016 budget will allow us to continue transforming to meet the intent of MyVA. It requests $168.8 billion; a $73.5 billion in discretionary funds, and $95.3 billion in mandatory funds for benefit programs. The discretionary request is an increase of $5.2 billion, or 7.5 percent above the 2015 enacted level, providing resources to continue serving the growing number of veterans seeking care and benefits.

The budget will increase access to medical care and benefits for veterans. It will address infrastructure challenges, including major and minor construction, modernization and renovation. It will end the backlog of claims, and it will end veteran homelessness in calendar year 2015. It will fund medical and prosthetics research, and it will address important I.T. infrastructure and modernization.

The resources required in the 2016 budget request are in addition to those Congress provided last year in the Veterans Choice Act. V.A. has implemented the Act. We want to be successful, and we will be expanding our outreach, and providing more information to veterans with a nationwide public-service announcement, which we will share with you the link so that you can see it.

But we don't know at this time how many veterans will use the provisions of the Act to seek non-V.A. care, or how much that care will cost. There is a high degree of uncertainty, as there is in any free marketplace with choice. Our current estimates of demand range from a low of about $4 billion for Choice Act, to a high of about $13 billion over a 3-year program.

We will need flexibility within our budget to ensure that we have the right resources at the right place, at the right time, to provide veterans the timely care they need, regardless of where they choose to get that care. As an example of this flexibility, we are currently exploring options to review the 40-mile provision of the Choice Act to get more veterans the care that they want.

I look forward to working with this committee, with other members of Congress, with veteran stakeholders, on this critical issue. We meet today at a historically important time for V.A. and our nation. Today marks the 150th anniversary of President Lincoln's solemn promise to care for those "who shall have borne the battle," and for their families and their survivors.

That is V.A.'s primary mission, the noblest mission supporting the greatest clients of any agency in the country. Mr. Chairman, members of the committee, thanks again for your support for veterans, for working with us on these budget requests, and for making things better for all veterans. We look forward to your questions, sir.

Department of Veterans Affairs

Senior Executive Biography

Robert A. McDonald

Secretary of Veterans Affairs

Robert A. McDonald was nominated by President Obama to serve as the eighth Secretary of Veterans Affairs and was confirmed by the United States Senate on July 29, 2014.

Prior to joining VA, Secretary McDonald was Chairman, President, and Chief Executive Officer of The Procter & Gamble Company (P&G). Under his leadership, P&G significantly recalibrated its product portfolio; expanded its marketing footprint, adding nearly one billion people to its global customer base; and grew the firm's organic sales by an average of three percent per year. This growth was reflected in P&G's stock price, which rose from $51.10 the day he became CEO to $81.64 on the day his last quarterly results were announced—a 60 percent increase from 2009 to 2013.

During his tenure, P&G was widely recognized for its leader development prowess. In 2012, Chief Executive Magazine named it the best company for developing leader talent. The Hay Group, a global management consulting firm, consistently cited P&G in its top-tier listing of the Best Companies for Leadership Study. The company received recognition for its environmental and social sustainability initiatives, including receipt of the Department of State's Award for Corporate Excellence for P&G's operations in Pakistan and Nigeria. In addition, using the company's innovative water purification packets, P&G committed itself to the 2020 goal of "saving one life every hour" by annually providing two billion liters of clean drinking water to people in the world's developing countries.

An Army veteran, Mr. McDonald served with the 82nd Airborne Division; completed Jungle, Arctic, and Desert Warfare training; and earned the Ranger tab, the Expert Infantryman Badge, and Senior Parachutist wings. Upon leaving military service, Captain McDonald was awarded the Meritorious Service Medal.

Secretary McDonald graduated from the United States Military Academy at West Point in the top 2 percent of the Class of 1975. He served as the Brigade Adjutant for the Corps of Cadets and was recognized by The Royal Society for the Encouragement of Arts, Manufacturing, and Commerce as the most distinguished graduate in academics, leadership, and physical education. He earned an MBA from the University of Utah in 1978.

The Secretary is personally committed to values-based leadership and to improving the lives of others. He and his wife, Diane, are the founders of the McDonald Cadet Leadership Conference at West Point—a biennial gathering that brings together the best and brightest young minds from the best universities around the world and pairs them with senior business, NGO, and government leaders in a multi-day, interactive learning experience.

The recipient of numerous leadership awards and honorary degrees, in 2014, Secretary McDonald was awarded the Public Service Star by the President of the Republic of Singapore for his work in helping to shape Singapore's development as an international hub for connecting global companies with Asian firms and enterprises.

Secretary McDonald and his wife are the parents of two grown children, and the proud grandparents of two grandsons.

STATEMENT OF THE HONORABLE ROBERT A. MCDONALD
SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES

BUDGET REQUEST FOR FISCAL YEAR 2016

MARCH 4, 2015

Chairman Dent, Ranking Member Bishop, Distinguished Members of the House Appropriations Subcommittee on Military Construction and Veterans Affairs:

Thank you for the opportunity to present the President's 2016 Budget and 2017 Advance Appropriations (AA) requests for the Department of Veterans Affairs (VA). This budget continues the President's staunch, unwavering support for Veterans, their families, and survivors. We value the support to VA that Congress has demonstrated in providing the resources and legislative authorities needed to honor our Nation's Veterans.

This is a critical moment for VA. We are emerging from one of the most serious crises the Department has ever experienced. But with this crisis, VA also has before it perhaps the greatest opportunity in its history to enhance care for Veterans and build a more efficient and effective system. We are listening hard to what Veterans, Congress, employees, Veterans Service Organizations (VSOs), and other stakeholders are telling us. Since my nomination on June 30, 2014, I have made 96 visits to VA field sites -- including 26 visits to VA Medical Centers, seven visits each to VA Community-Based Outpatient Clinics and Homeless Veteran program sites. I participated in the Los Angeles Point-in-Time Homeless Veterans count. I've made six visits to VA Regional Offices and five visits to VA cemeteries. I have witnessed first-hand the operations at VA polytrauma centers, a Veterans community living center, a hospice, an insurance center, and a domiciliary. I have attended nineteen Veteran engagements through partnerships and sixteen stakeholder events. I have visited twelve medical schools and universities to recruit newly minted clinical professionals for VA's healthcare system. All of these visits are influencing the way VA is moving forward. We are implementing an historic department-wide transformation, changing VA's culture, and making the Veteran the center of everything we do. We aspire to make the VA a model agency that is held up as an example for other government agencies to follow with respect to customer experience and stewardship of the taxpayer's resources. We strive to be comparable to the very best private sector businesses, with efficient and effective operations.

The President's 2016 Budget will allow VA to operate the largest integrated healthcare system in the country, including over 1,900 VA points of healthcare and approximately 9.4 million Veterans enrolled to receive care; the tenth largest life insurance provider, covering both active duty Servicemembers and enrolled Veterans; a compensation and pension benefits program serving over 5.2 million Veterans and survivors; an education assistance program serving 1.2 million students; a home mortgage program with a portfolio of over 2 million active loans guaranteed by VA; and the largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter 129,200 Veterans and family members in 2016. VA's 2016 budget request is essential to begin to address the resource requirements necessary to move VA into the future, address the crisis we are in, and meet our obligation to provide timely, quality health care and services to Veterans.

The 2016 Budget for VA requests $168.8 billion -- $73.5 billion in discretionary funds, including medical care collections, and $95.3 billion in mandatory funds for Veterans benefits programs. The discretionary request reflects an increase of $5.2 billion (7.5 percent) above the 2015 enacted level. The budget also requests a 2017 AA for Medical Care of $63.3 billion and a first-time AA request of $104.0 billion for three mandatory accounts that support veterans' benefit payments (i.e., Compensation and Pensions, Readjustment Benefits, and Insurance and Indemnities). These investments, together with the 2016 Budget, will provide authorities, funding, and other tools to enhance service to Veterans in the short term while strengthening the underlying VA system to better serve Veterans in the future. However, more resources in certain areas will be required to ensure that the VA system can provide timely, high-quality health care into the future. In the coming months, the Administration will submit legislation to allow the VA Secretary to reallocate a portion of Veterans Choice Program funding to best meet Veteran needs. This will allow the Secretary to make essential investments in VA system priorities in a fiscally responsible, budget-neutral manner.

MyVA -- Driving Reforms and Improving Efficiency

In order to transform VA into an organization of which Veterans, employees, and Americans can be proud, we are beginning with a commitment to critically assess ourselves. Transformation must start with organizational reforms to better unify the Department's efforts on behalf of Veterans. These reforms will take time, but will center around the ICARE values and provide Veterans the services and benefits they have earned and deserve.

The goal of MyVA is to reorient the Department around the needs of Veterans. MyVA will create a VA that eliminates barriers to putting customers first; measures success by the outcomes to Veterans as opposed to our internal processes; and integrates across programs and organizations to optimize productivity and efficiency. MyVA focuses on five major themes:

- Improving the Veteran experience
- Improving the employee experience, and achieving "people excellence" so we can better serve Veterans
- Establishing a culture of continuous improvement
- Improving our internal support services
- Enhancing strategic partnerships

The overarching principle is our focus on the Veteran experience. We want every Veteran to have a seamless, integrated, and responsive customer service experience every time. We are taking the first step towards better integration of the Department by moving from nine separate regional maps to one. This realignment will align VA's disparate organizational boundaries into a single framework, easing internal coordination and collaboration between business lines, and allowing VA to provide customer service training and capabilities across the agency. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA, rather than individual organizations. The new organizational framework will have five geographically-named regions, which we worked with Veteran Service Organizations to name: North Atlantic, Southeast, Midwest, Continental, and Pacific.

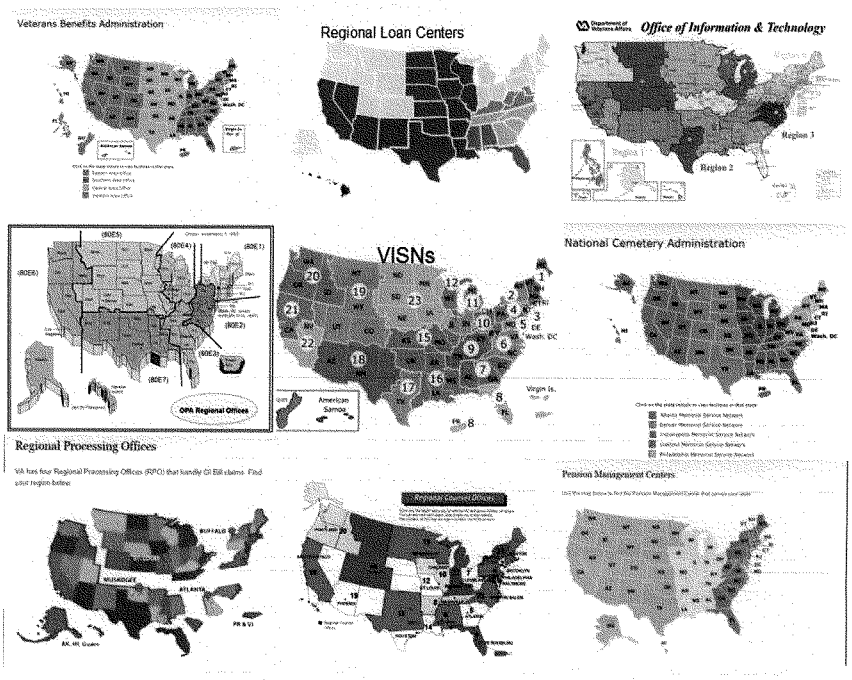
MyVA will empower employees with the tools they need to better serve Veterans, and will revolutionize VA's culture by emphasizing continuous improvement, setting conditions at the local level for issues to be raised, addressed, and solutions replicated across as many facilities as needed to achieve enterprise level results.

MyVA is also about ensuring that VA is a sound steward of the taxpayer dollar. By improving our internal support services, we will ensure that our processes support VA employees serving Veterans and that we effectively balance exceptional Veteran-centric service with operational efficiency. We are using a business lens to assess all aspects of VA operations and will pursue changes to allow VA to deliver care and services more efficiently and effectively while delivering the highest value to Veterans and taxpayers. By exploring opportunities to enhance Strategic Partnerships, we will ensure the best and most effective organizations—public, private, non-profits, and volunteer—work with VA to best serve Veterans.

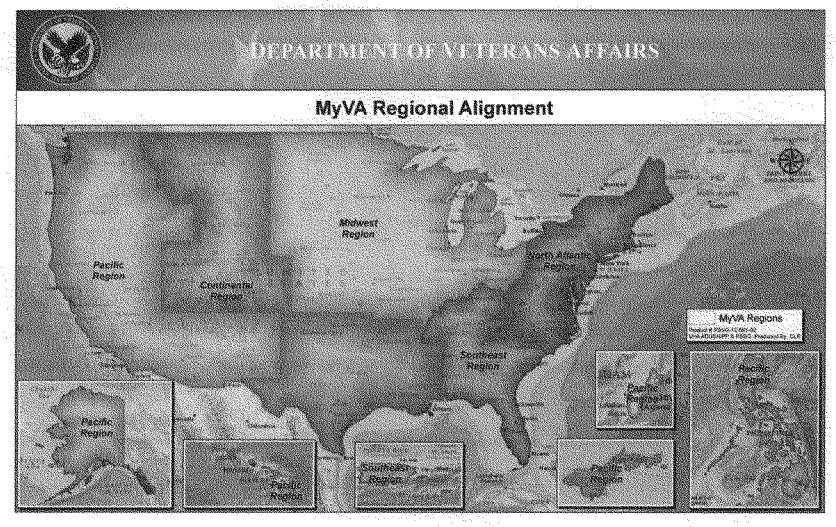
In addition, we are creating a new Digital Services Team, comprised of the country's best developers, designers, and digital product managers, who will work across VA to design and deploy world-class digital services for America's Veterans. Our digital services experts will help the Department achieve the MyVA vision through improved electronic access to VA services that works across Veterans' computers, tablets, kiosks, and mobile devices.

We anticipate this will be the largest department-wide transformation in VA's history. It will be the product of ideas and insights shared by Veterans, employees, members of Congress, VSOs, and other stakeholders.

Before: VA's Nine Organizational Maps

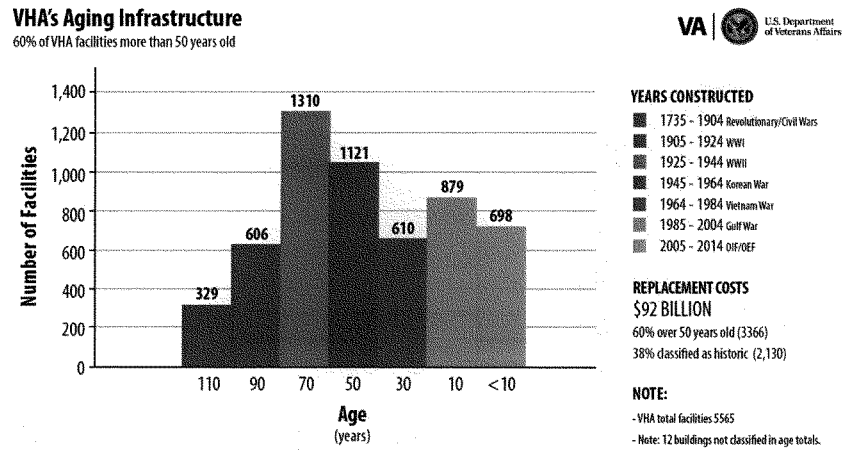


After: A Single, Coordinated Framework



Closing Unsustainable Facilities

VA cannot be a sound steward of the taxpayer's resources with the asset portfolio it is carrying. No business would carry such a portfolio – and our Veterans deserve better. It is time to close VA's old, substandard, and underutilized facilities. Of 5,565 VA medical facilities – which include hospitals, clinics, warehouses, and other assets that support medical operations – more than 900 facilities are over 90 years old, and more than 1,300 facilities are over 70 years old. Overall, 60 percent of VA facilities are more than 50 years old.



We need to move forward with closing locations that are not economically sustainable and old, outdated buildings that are challenging to maintain and provide little or no value to our customers. VA currently has 336 buildings that are vacant or less than 50 percent occupied, which are excess to our needs. This means we have to maintain over 10.5 million square feet of unneeded space – taking funding from needed Veteran services. For example, we estimate that it costs VA $24 million annually to maintain and operate vacant and underutilized buildings. These funds could be better used to hire roughly 200 Registered Nurses for one year; pay for 144,000 Veteran primary care visits; provide Veterans 13,500 bed days of inpatient care; or support 41,900 days of nursing home care for Veterans in Community Living Centers. The President's 2016 Budget includes two legislative proposals that would aid VA in disposing of these unnecessary assets. The first is the government-wide Civilian Property Realignment Act, which would enable Federal agencies to pursue consolidation and disposals in a streamlined way. The second proposal would authorize VA to pursue Enhanced-Use Lease (EUL) agreements for purposes beyond the currently authorized purpose of creating supportive housing. Our existing EUL authority does not allow VA to enter into a wide range of innovative agreements that could benefit Veterans.

VA faces many obstacles to rightsizing our capital asset portfolio. For example, under an Enhanced Use Lease project, VA and a third-party developer tried to demolish the vacant building shown below in order to provide land for the development of housing for homeless Veterans, but the state historic preservation office prevented VA from

taking action. I have met with National Historic Building advocates to discuss repurposing the buildings we close, and look forward to a spirited, positive dialogue on this issue.

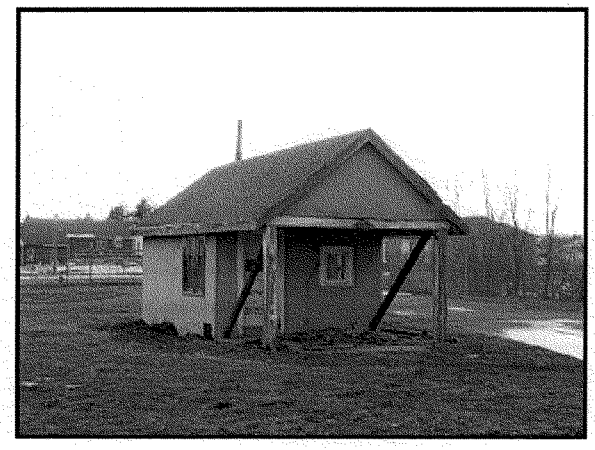


Photo: Minneapolis, Minnesota vacant building, quartermaster gas station, built in 1932.

As the Veteran population has migrated, VA's capital infrastructure has not kept pace. We continue to operate medical facilities in legacy locations, in places where the Veteran population is small or shrinking. We do this at the expense of creating new access and right-sized capacity for larger numbers of Veterans in the locations where the Veteran population is growing. For example, in one hospital with an operating capacity of ten medical beds, the average daily patient census is 5 patients or less. At this facility, VA is required to maintain adequate infrastructure such as lab, x-ray, and other support in place continuously, regardless of the facility's low utilization rate. The cost per patient to maintain a small operation such as this one is higher than the cost in some of our large, highly complex facilities. Additionally, the patient volume and complexity of care make it difficult, if not impossible, for physicians and nurses to maintain clinical skills and competencies. This example is not an anomaly – there are many others in VA.

VA needs to better align its health care facilities to meet today's health care delivery models, which are shifting away from long inpatient stays to greater outpatient care. We also need to modernize our facilities to ensure they provide ready access to women, who now comprise 11 percent of all Veterans and 20 percent of our military. Where hospitals no longer make sense, due to a declining Veteran population or

demographic shifts, VA must look for ways to partner with local hospitals and health care systems to serve Veterans. Much of health care today is about creating partnerships and interdependencies to better serve patients and to contain costs. VA must be part of that.

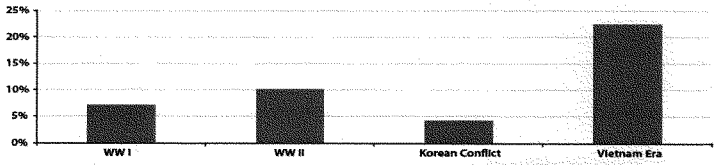
We know that it is difficult for Members of Congress to contemplate the closing of a facility in their own District, even when that facility is underutilized and wasteful. Yet, given the current and future demands on the VA system, we cannot afford to waste scarce resources on an inefficient system. We would like to work with Members of Congress to do the harder right, rather than the easier wrong. We ask for your help to realign our Medical facilities to best serve our Veterans and shed facilities that are not economically viable and no longer provide value.

Veterans' Demand for Services and Benefits

We know that Veterans' demand for services and benefits continues to rise for decades after conflicts end. And we know that the Veteran population is aging. In 2017, 9.8 million, or 46 percent of the 21.1 million Veteran population will be age 65 or older. This compares with 2.2 million, or 7.5 percent, in 1975. Veterans' care often occurs many years after they served in uniform, so this is a long-term issue for VA. Just since 2002, the number of Veterans receiving outpatient services has grown by more than 76 percent.

Veterans Receiving Service Connected Disability Compensation
40 years after conflict ends

VA | U.S. Department of Veterans Affairs

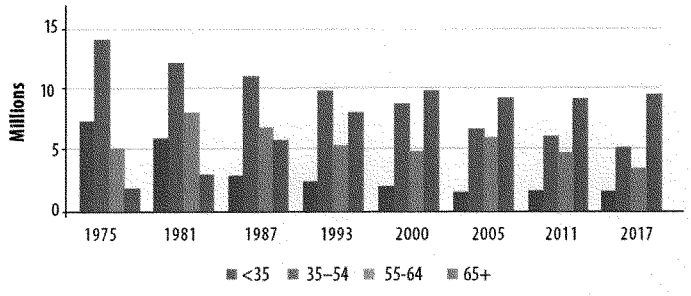


	World War I Veterans (1958)	World War II Veterans (1985)	Korean Conflict Veterans (1993)	Vietnam Era Veterans (2014)
SCD Compensation	203,654	1,048,976	198,492	1,624,656
Total Population	2,876,000	10,399,000	4,692,000	7,247,000
Percentage	7.08%	10.09%	4.23%	22.42%

Note: Date in parentheses is the date of data used in the chart
Data Source: 1958 VA Annual Report; 1985: VA Trend Data 1961-1985;
1993 VA Trend Data 1969-1993; 2014: VBA OPIA and Veteran Population Model

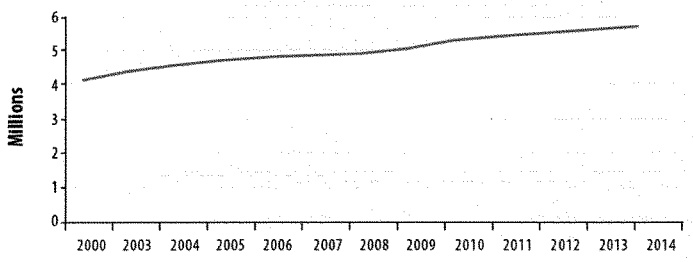
Number of Living Veterans
by Age Groups, 1975-2017

VA | U.S. Department of Veterans Affairs

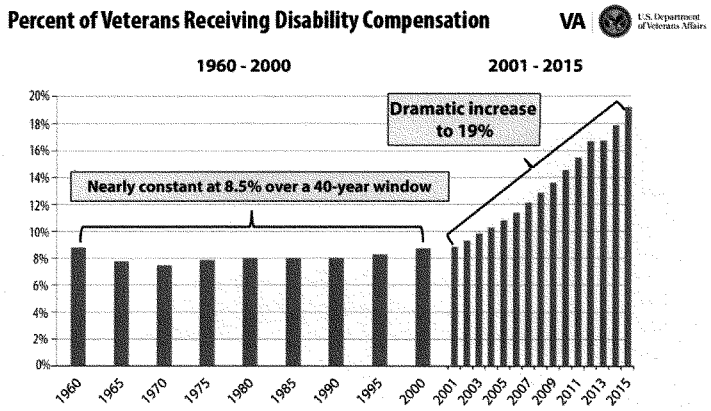


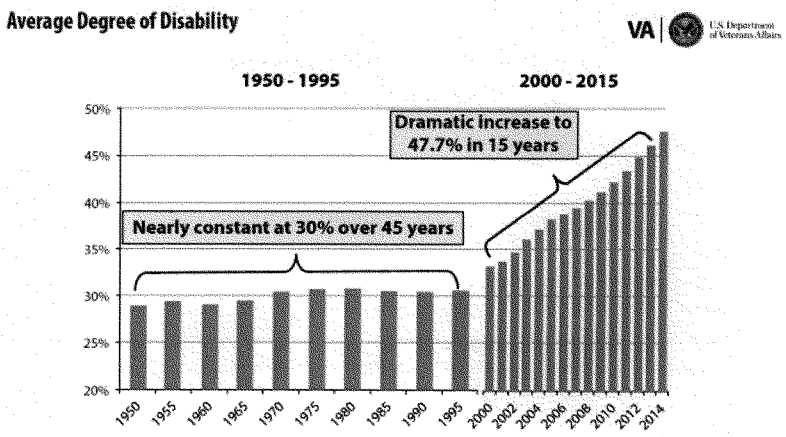
Number of Veterans Unique Outpatients
2002-2014 (in millions)

VA | U.S. Department of Veterans Affairs



Fueled by more than a decade of war, Agent Orange-related disability compensation claims, an complex, non-linear claims appeal process, demographic shifts, increased medical claims issues, and other factors, Veterans' demand for services and benefits has exceeded VA's capacity to meet it. VA has worked with the Ad Council on a pro bono advertising campaign to encourage more Veterans to sign up for their benefits, but we are reluctant to launch the campaign at a time when our capacity is stretched to its limit.





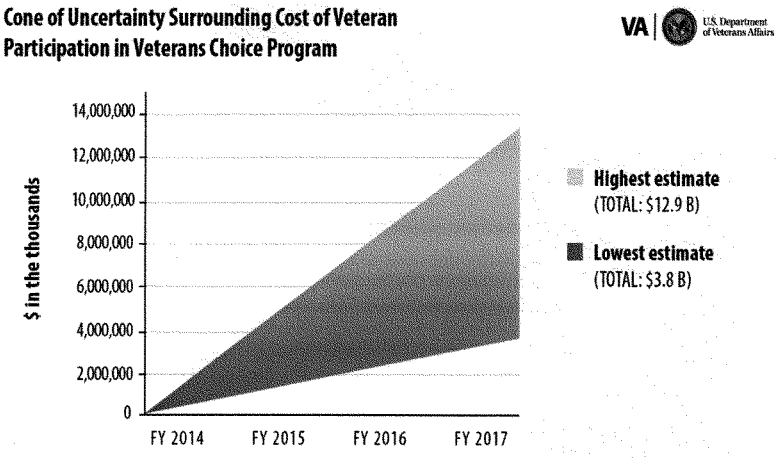
We must ensure that demand for services and benefits does not outstrip our capacity to provide them. VA must build the capacity now to meet future demand. We

look forward to working with you to identify and prioritize spending to best serve the interests of Veterans and our Nation.

The Veterans Access, Choice, and Accountability Act of 2014

The funding provided in the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act) was an important step in moving VA on the path to improved access to care for Veterans. VA greatly appreciates these additional resources provided by the Congress - $15 billion to allow Veterans additional access to health care within the community and address current access and capacity shortfalls that are inherent within VA. While it is clear that purchased care plays an important role, it should not be seen as a replacement for a strong and vital Veterans' healthcare system.

The emergency resources provided in the Veterans Choice Act are not permanent, but are being used to address the current access crisis, but do not fully address VA's longstanding capital infrastructure requirements because VA has limited experience with the new Veterans Choice Program, it is difficult to predict Veterans' use of the program, or its interaction with the medical care base budget. Our estimates of the total health care costs for the Choice Program range from a low of $3.8 billion to a high of $12.9 billion over the three-year program.



Data source: VA Office of the General Counsel, Economic Impact Analysis for RIN 2900-AP24, "Expanded Access to Non-VA Care through the Veterans Choice Program"

The variance is the result of significant uncertainty surrounding eligible Veterans' participation and utilization of non-VA medical services. Two categories of Veterans are eligible to participate -- those living outside the Act's 40-mile distance from a VA facility, and those who are on a waiting list for more than 30 days. Each eligible Veteran must make his or her own decision about care in the community. For example, a Veteran may prefer to be seen at the VA by his or her regular doctor, even though there is a waiting period, rather than see a new private sector physician in a shorter time period. Also, wait times may be high in the community for specialty appointments, and Veterans may elect to receive their specialty care from VA.

Ensuring Veterans Access to Care

Veterans are demanding more services from VA than ever before. The number of Veterans who are seeking VA medical care continues to grow steadily. Compared to FY 2009, the number of patients is projected to increase by 20 percent by FY 2016. We now serve a population that is older, with more chronic conditions, and less able to afford care in the private sector. And, as Veterans see the results of the positive changes we are making, we are confident that the number of Veterans utilizing VA services will rise. Currently, 11 million of the 22 million Veterans in this country are registered, enrolled, or use at least one VA benefit or service. Our 2016 budget requests the necessary resources to allow us to serve the growing number of Veterans who selflessly served our Nation.

In 2016, the number of Veterans enrolled in VA medical care will be nearly 9.4 million, an increase of 1.6 percent from 2015. Also, VA expects to provide more than 101 million outpatient visits in 2016, an increase of 2.8 million visits from 2015. Workload will continue to rise as the military downsizes and Veterans regain trust in the VA. In addition, survival rates among Americans who served in conflicts have increased, and more sophisticated methods for identifying and treating Veteran medical issues continue to become available.

The 2016 Budget requests $60.0 billion for medical care, an increase of $4.2 billion (7.4 percent) over the 2015 enacted level. The increase in 2016 is driven by Veterans' demand for VA health care as a result of demographic factors, and economic assumptions, investments in access; and high priority investments for Caregivers, new Hepatitis C treatments, and support for Veterans Health Information Systems and Technology Architecture (VistA) Evolution. The 2016 request supports programs to end Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. The 2016 appropriations request includes an additional $1.3 billion above the enacted 2016 AA for Veterans medical care. This is

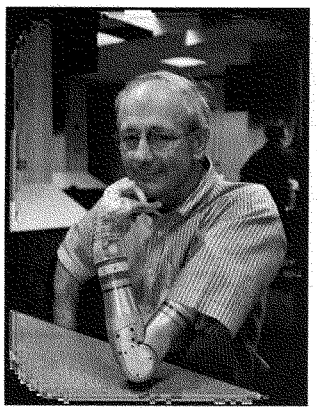
the first year VA will be seeking additional funding in all three medical care accounts that are funded by advance appropriations. The request includes approximately $3.3 billion annually in medical collections in 2016 and 2017.

For the 2017 Advance Appropriations for medical care, the current request is $63.3 billion. This request reflects great uncertainty surrounding the impact of the Veterans Choice Act on VA operations in 2017. This estimate will be revised as VA gains greater experience with implementation of the Veterans Choice Act.

Ending Veteran Homelessness

As President Obama has said, too many of those who once wore our nation's uniform now sleep in our nation's streets. The Administration has made the elimination of Veteran homelessness a national priority. In 2009, we set an ambitious plan to end veteran homelessness by the end of 2015. We have made substantial progress toward this goal — as of January 2014, overall Veteran homelessness is down 33 percent since 2010, and we have achieved a 42 percent decrease in unsheltered veteran homelessness. Through unprecedented partnerships with federal and local partners, we have greatly increased access to permanent housing, a full range of health care including primary care, specialty care, and mental health care; employment; and benefits for homeless and at risk for homeless Veterans and their families. As a result of these investments, in fiscal year 2014, more than 260,000 homeless or at-risk Veterans (including formerly homeless Veterans) received VA specialized services.

In 2016, VA will continue to focus on prevention and treatment services. The Budget requests $1.4 billion for VA homeless-related programs, including case management support for the HUD-VASH voucher program, the Grant and Per Diem Program, the Supportive Services for Veteran Families program, and VA justice programs. The 2016 Budget supports VA's plan to end Veteran homelessness by emphasizing rescue for those who are homeless today, and prevention for those at risk of homelessness.



Medical and Prosthetic Research

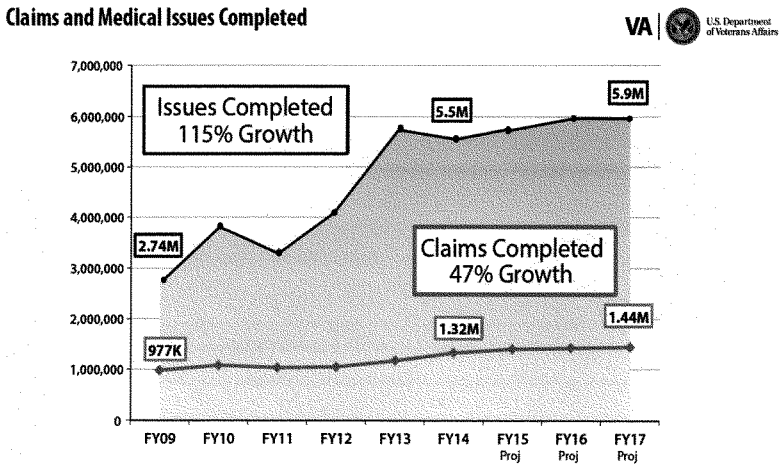
VA has a legacy of innovation and cutting-edge research that is as broad and historically significant as it is profound—and often unrecognized. Few are aware that VA research developed the cardiac pacemaker, the first successful liver transplant, the nicotine patch, and the world's most advanced prosthetics—including VA's revolutionary "Braingate" breakthrough that makes it possible for totally paralyzed patients to control robotic arms using only their thoughts.

VA research also has led to major breakthroughs and advances in medical science and care—Posttraumatic Stress Disorder, or PTSD, and Traumatic Brain Injury, or TBI, being only two of many. In 2016, Medical Research will be supported through a $621.8 million direct appropriation, and an additional $1.2 billion from VA's medical care program and grants. Total funding for Medical and Prosthetic Research will be over $1.8 billion in 2016.

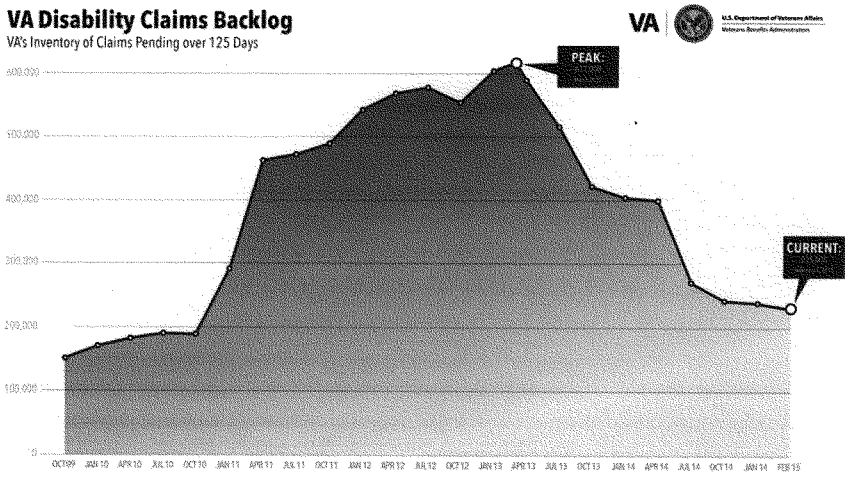
The 2016 Budget includes a $10.2 million strategic initiative to support improvements in VA medical care through research focused on a "Learning Health Care System." A learning health care system is one that is responsive to new information, adapts to implement more effective clinical practices, and is committed to an ongoing mission of excellence, supported by a culture of self-reflection and continuing education. Through five interlocking research streams – measurement science, operations research, point-of-care research, provider behavior, and randomized program implementation – this initiative proposes to broaden existing research by systematically capturing, assessing, and translating the lessons from each care experience into improved methods of delivering care to Veterans.

Continuing the Transformation of the Veterans Benefits Administration

Improving quality and reducing the length of time it takes to process disability compensation claims is integral to our mission of providing the care and benefits that Veterans have earned and deserve in a timely, accurate, and compassionate manner. The disability rating claims workload continues to increase, due to the reduction in military forces, Servicemembers returning from wars, and the aging of the Veteran population. Also, the complexity of the workload continues to grow because Veterans are claiming greater numbers of disabling conditions and the nature of disabilities -- such as PTSD, combat injuries, diabetes and related conditions, and environmental diseases -- is becoming increasingly complex.



Despite these challenges, VBA has decreased the disability claims backlog by more than 60 percent as of January 31, 2015, since its peak in March 2013 (from 611,000 to 235,000), and we are on track to meet the President's goal to eliminate the disability claims backlog by processing all claims in 125 days by the end of 2015. VBA's success in reducing the backlog has occurred, in part, because of its strong reliance on mandatory overtime by claims processors. However, this strategy is unsustainable. It strains employee-management relations and is inconsistent with our goal to improve the employee experience so they can be empowered to better serve Veterans. We must right size VBA's workforce and more effectively manage the use of management practices such as the use of mandatory overtime and continue progress toward eliminating the disability claims backlog.



We are taking the lessons learned in eliminating the disability claims backlog and applying them to transform business processes supporting the fiduciary program, the delivery of non-rating benefits, and the appellate workload.

For 2016, VA requests $2.7 billion for VBA for general operating expenses, an increase of $165.8 million (6.6 percent) over the 2015 enacted level. These resources will support 21,871 Full-Time Equivalent (FTE) employees and allow VA to administer disability compensation and pension benefits totaling $83.1 billion to over 5.2 million Veterans and survivors; education benefits and vocational rehabilitation and employment benefits and services to nearly 1.3 million participants; VA guaranty of more than 431,000 new home loans; and life insurance coverage to 1.1 million Veterans, 2.3 million Servicemembers, and 3.1 million family members.

As VBA continues to receive and complete more disability rating claims, the volume of appeals, non-rating claims, and fiduciary field examinations increases correspondingly.

- Appeals. Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims in recent years (1.3 million claims completed in 2014), the volume of appeals increases concomitantly. VBA currently has approximately 290,000 pending appeals.

- Non-rating claims. VBA's success in completing rating decisions has driven an increase in non-rating claims. In 2015, VBA expects to receive 2.9 million non-rating claims and review actions, an increase of 7.4 percent over 2014 (2.7 million) and 12.5 percent over 2013 (2.4 million).

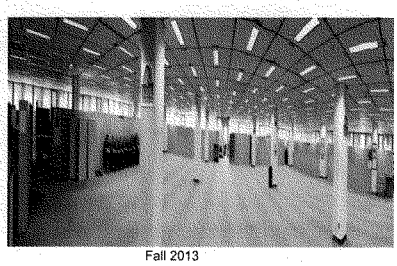
- Fiduciary program. In 2014, VA's fiduciary program protected more than 173,000 beneficiaries, which is a 42 percent increase in the number of beneficiaries from 2011 (122,000). Primary drivers of the growth in this program are the increase in the total number of beneficiaries receiving VA benefits and an aging beneficiary population. In 2014, fiduciary personnel conducted over 86,000 field examinations, and VBA anticipates field examination requirements to exceed 117,000 in 2016.

To ensure all aspects of the claims process are improved for Veterans, VBA is requesting additional claims processors and field examiners. VBA is requesting $85 million to fund 200 appeals processors, 320 non-rating claims processors, 85 fiduciary field examiners, and 165 support personnel (including 13 FTE for the National Work Queue (NWQ)), for a total of 770 additional FTE. VBA employees – over 50 percent of whom are Veterans - are leading advocates for Veterans, Servicemembers, their families, and Survivors and are key to our success. With the additional 770 employees, VA will provide Veterans with more timely decisions on their appeals and non-rating claims, and conduct thousands more vital fiduciary home visits.

VBA is able to accommodate additional staff within existing space requirements by efforts underway to digitalize Veterans claims folders, building on success to date. One example is the VBA office in Winston-Salem, North Carolina, which is shown below before and after VBA digitized Veterans' paper records.

Winston-Salem Regional Office: Before and After Transformation

Spring 2012



Fall 2013

The VBA request includes $140.8 million for continued investment in the Veterans Claims Intake Program (VCIP), which converts paper claims into an electronic format and enables the electronic transfer of medical and personnel records. This

electronic transfer is critical to creating the necessary digital environment that supports end-to-end electronic claims processing for each stage of the claims lifecycle. As of December 2014, over 28,000 users of the Veterans Benefits Management System (VBMS) could access over one billion electronic images converted from paper.

The Budget request for the 2017 Advance Appropriations for the Compensation and Pensions appropriation is $87.1 billion; the Readjustment Benefits advance appropriation request is $16.7 billion; and the Veterans Insurance and Indemnities advance appropriation is $91.9 million. These amounts reflect the current estimates for the resources that would be necessary to continue these benefit programs in 2017, and will be revised as necessary in the mid-session review of the 2016 Budget, as VA monitors workload and monthly expenditures.

Enhanced Focus on Information Technology Solutions

Funding for IT infrastructure and services is at the heart of VA's mission, because IT affects every aspect of VA's ability to serve Veterans by providing easily accessible, quality health care and benefits. To offer a view of the scope of VA's IT dependency, VA IT systems support operations at every VA location, with over a million devices on the network. VA's current challenges present a unique opportunity to employ innovative Information Technology (IT) solutions to accelerate changes that will better serve Veterans. Veterans and their families of all ages are increasingly more comfortable using leading-edge technology to communicate and access health care and benefits. Our IT challenge is to safely and securely deliver Veterans that leading-edge experience—fluid mobile solutions, creative apps, and user-friendly websites that rival the best in technology outside VA.

The $4.1 billion request represents an increase of $230 million (6 percent) above the 2015 enacted level. The request consists of $505 million for development of new IT products; $2.5 billion for sustainment, $892 million for more than 7,615 staff and administrative support, and $223 million for related support services. The request will sustain our infrastructure while making necessary investments in IT support for critical business processes, such as streamlining benefits processing, enhancing and modernizing VA's electronic health record, enhancing data security, and achieving health data interoperability with the Department of Defense.

The 2016 request funds key development projects for Veterans' access ($192 million), disability claims backlog elimination ($105 million), and VistA Evolution ($82 million). The request of $2.5 billion for IT sustainment will fund the replacement of the oldest hardware that has fallen beyond its useful lifespan; the development of registries to track homeless Veterans; communications systems, wireless, and mobile solutions; software license procurement; and information security.

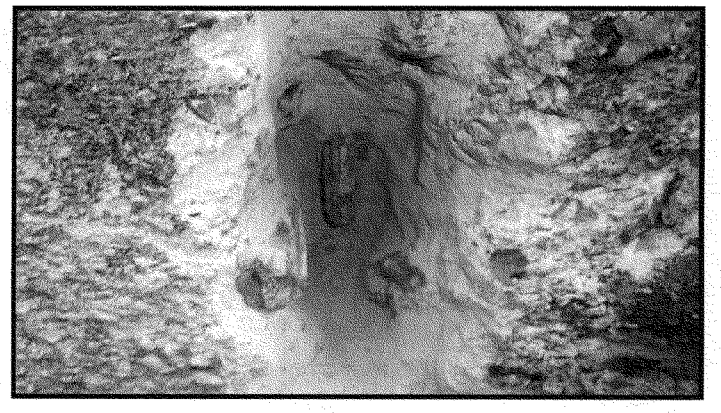
Investing in VA's Infrastructure

The 2016 Budget requests $1.6 billion for VA's major and minor construction programs, an increase of $493 million (47 percent) above the 2015 enacted level. Providing access to care and ensuring that Veterans are safe when they are in a VA facility, drive our capital requirements. The capital asset budget demonstrates VA's commitment to address critical major construction projects that directly affect patient safety and seismic issues, and reflects VA's promise to provide safe, secure, sustainable, and accessible facilities for Veterans. The request enables VA to invest in our facilities to fulfill VA's mission to deliver timely and high quality care and services to our Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gaps identified in our Strategic Capital Investment Planning (SCIP) process.

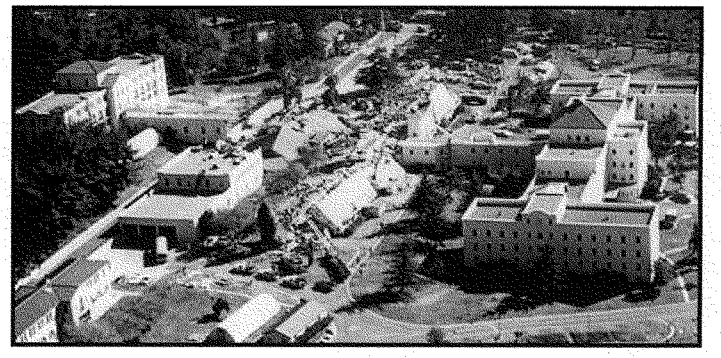
Major Construction

VA acknowledges the challenges we have experienced in building the Denver Replacement Medical Center facility in Aurora, Colorado. We are committed to doing what is right for the Veterans in Denver and completing this major construction project without further delay. VA is dedicated to getting the project back on track in the most effective and cost efficient manner possible.

The 2016 Budget requests $1.144 billion for major construction, an increase of $582 million from the 2015 enacted level. The request provides funding for nine on-going VHA major medical facility projects. Correction of seismic deficiencies is a primary focus of our 2016 Major construction request. The request includes funds to address seismic problems in facilities in America Lake, WA; and in San Francisco, West Los Angeles, and Long Beach, CA. These projects will correct critical safety and seismic deficiencies that pose a risk to Veterans, VA staff, and the public. The photograph below shows a known seismic deficiency at the San Francisco Medical Center -- built in 1933 -- wherein the rebar does not extend into the "pile cap."



We must prevent the devastation and potential loss of life that occurs because our facilities are vulnerable to earthquakes – such as occurred in 1971 in San Fernando, California. As shown below, a 6.5-magnitude earthquake caused two buildings in the San Fernando Medical Center to collapse and 46 patients and staff to lose their lives.



The Major construction request also includes funds for medical facility improvements and cemetery expansion project in St. Louis, MO (Jefferson Barracks); new medical facility project in Louisville, KY; construction of a new outpatient clinic and a columbarium in Alameda, CA; realignment and closure of the Livermore Campus in Livermore, CA; and construction of a replacement Community Living Center in Perry Point, MD. New, replacement, and renovated medical space will provide additional capacity to treat Veterans through more efficient configurations, with the implementation of Patient-Aligned Care Teams, and the establishment of multi-exam rooms per provider – similar to the private sector. Once the projects are completed, Veterans will be served in modern and safe facilities.

The major request also includes funding for four cemetery gravesite expansion projects at: Puerto Rico National Cemetery; Willamette National Cemetery in Portland, OR; Riverside National Cemetery in Riverside, CA; and Barrancas National Cemetery in Pensacola, FL. These projects offer VA the ability to provide access to burial services through new and expanded cemeteries and prevent the closure to new interments in existing cemeteries.

Minor Construction

In 2016, the minor construction request is $406.2 million. The requested amount would provide funding for ongoing and newly identified projects that renovate, expand and improve VA facilities, while increasing access for our Veterans. VA continues to focus on a balance between continuing to fund minor construction projects that can be implemented quickly to maintain and repair our aging infrastructure, while using major construction funding to address life-threatening safety and seismic issues that currently exist at multiple VA medical facilities.

Leasing

The 2016 Budget includes a request to authorize 18 major medical leases to provide access to Veterans and enhance our research capabilities nationwide. The proposed major medical lease projects are to replace, expand, or create new outpatient clinics and research facilities. The request includes resubmission of five leases that were originally submitted in 2015, but have not yet been authorized.

Since the inception of the EUL program, VA has entered into approximately 100 EUL projects, leveraging approximately 5.8 million square feet and over 1,000 acres of excess property to repurpose in support of Veterans, VA, and local communities across the country. VA needs the support of Congress for our proposed amendments to expand our current EUL authority beyond supportive housing projects so we can better leverage our excess space for Veterans. In addition, this proposed enhancement would allow VA to monetize unneeded assets to raise capital to address needed investments in VA's system.

Legislation

In addition to presenting VA's resource requirements, the 2016 President's Budget proposes legislative action that will benefit Veterans. VA's most critical legislative request is for a significant update to VA's authorities for purchase of non-VA healthcare. The Administration is proposing a streamlined process for purchasing health care needed for Veterans in those circumstances where it cannot be purchased through existing contracts or sharing agreements. The proposal takes care to preserve important features and protections found in traditional contract vehicles. Current law is simply not adequate to support the continued level of access to health care we need to secure for our Veterans. We look forward to detailed engagement with the Committee and your staff.

Other important proposals include adjustment for VHA personnel authorities, one of which will greatly help in having employee scheduling flexibility that will both make hospital operations more efficient, and help attract the most qualified medical professionals to work for VA, especially for critical round-the-clock operations. VA in this budget also again proposes changes in disability claims processes, an area where reform is greatly needed, for the benefit of all Veterans who are frustrated with the time it takes to resolve claims and appeals. We are open to all ideas from the Committee and from VSO's to modernize this process, and make it work for Veterans. Our increased manpower and great strides in automation are helping, but these cannot replace statutory changes to modernize the process.

As mentioned earlier, VA will propose a measure that would allow a portion of the Veterans Choice Act funds to be used for essential operational requirements. In addition, the legislative proposals would allow for better coordination of care when a Veteran also receives other care at a non-VA hospital, by streamlining the exchange of patient information. Additionally, we propose allowing the CHAMPVA to cover children

up to age 26, to make that program consistent with benefits conferred under the Affordable Care Act.

To continue our priority to end Veteran homelessness, VA proposes increased flexibility in the Grant and Per Diem program to focus on the transition to permanent housing. Also among our proposals is a measure that would allow VA to speed payment of Dependency and Indemnity Compensation and other benefits to surviving spouses by eliminating the need for a formal claim when there already is sufficient evidence for VA to act. We are proposing legislation to eliminate the requirement for quarterly conference reporting. This requirement has impacted essential VA training and has taken a massive staff effort to produce the mandated reports. Since the beginning of fiscal year 2013, VA has spent $2.4 million to prepare these reports. These resources are better spent providing health care and benefits to Veterans. We greatly appreciate consideration of these and other legislative proposals included in the 2016 Budget and look forward to working with the Congress to enact them.

Closing

Veterans are VA's sole reason for existence and our number one priority. In today's challenging fiscal and economic environment, we must be diligent stewards of every dollar and apply them wisely to ensure that Veterans—our clients—receive timely access to the highest quality benefits and services we can provide and which they earned through their sacrifice and service to our Nation.

We also acknowledge the responsibility, accountability, and importance of showing measurable returns on that investment. You have my pledge that VA will do everything possible to ensure that the funds Congress appropriates to VA will be used to improve both the quality of life for Veterans and the efficiency of our operations. We are proud to be part of this VA team and feel privileged to be here serving Veterans at this key time in history. The work we do continues and grows for decades after the end of America's conflicts. Thank you for the opportunity to appear before you today and for your steadfast support of Veterans.

Department of Veterans Affairs

Washington, D.C.

Carolyn M. Clancy

Interim Under Secretary for Health

Carolyn M. Clancy, M.D., was named Interim Under Secretary for Health for the Department of Veterans Affairs, on July 2, 2014. As Interim Under Secretary for Health, Dr. Clancy oversees the health care needs of millions of Veterans enrolled in VHA, the United States' largest integrated health care system, with more than 1700 sites, including hospitals, clinics, long-term care facilities, and Readjustment Counseling Centers. In addition, VHA is the nation's largest provider of graduate medical education and a major contributor to medical research.

Prior to assuming the duties of the Interim Under Secretary for Health, Dr. Clancy was the Assistant Deputy Under Secretary for Health, for Quality, Safety and Value where served as the Chief Quality Management Officer for VHA – planning, directing, coordinating, and evaluating VHA's national quality, safety, and value-producing programs and approaches.

Dr. Carolyn M. Clancy also served as Director of the Agency for Healthcare Research and Quality (AHRQ), from February, 2003 through August, 24, 2013.

Dr. Clancy, a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following clinical training in internal medicine, Dr. Clancy was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. Before joining AHRQ in 1990, she was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia.

Dr. Clancy holds an academic appointment at George Washington University School of Medicine (Clinical Associate Professor, Department of Medicine) and serves as Senior Associate Editor, Health Services Research. She serves on multiple editorial boards including JAMA, Annals of Family Medicine, American Journal of Medical Quality, and Medical Care Research and Review.

She is a member of the Institute of Medicine and was elected a Master of the American College of Physicians in 2004. In 2009, was awarded the 2009 William B. Graham Prize for Health Services Research.

Her major research interests include improving health care quality and patient safety, and reducing disparities in care associated with patients' race, ethnicity, gender, income, and education. As Director, she launched the first annual report to the Congress on health care disparities and health care quality.

Allison A. Hickey
Under Secretary for Benefits - VBA

Allison Hickey was appointed Under Secretary for Benefits in the Department of Veterans Affairs on June 6, 2011. In this position, she leads more than 20,000 employees in the Veterans Benefits Administration (VBA) in the delivery of a wide range of integrated programs of non-medical benefits and service to more than 12 million Veterans, Servicemembers, their families and Survivors. Through a nationwide network of 56 regional offices, special processing centers, and VBA headquarters, she directs the administration of seven distinct lines of business: VA's disability compensation, pension and fiduciary, education, home loan guaranty, vocational rehabilitation and employment, life insurance programs, and transition assistance programs, and an annual budget of more than $94 billion.

Under Secretary Hickey currently leads a six-year, multi-billion dollar transformation effort at VBA to improve the quality and timeliness with which Veterans' benefits are processed and delivered. Under her leadership, in less than two years, VBA has converted claims processing from a paper-bound process to a digital operating environment where claims for VA benefits and services can be submitted, processed and delivered online, electronically. For the first time in history, Veterans can file their claims online; upload their documentation; and check their claim status through a multi-channel Veteran relationship management system that includes a one-stop-shop Web portal with nearly 60 self-service features. In addition, she led the transformation of VBA's training and quality management improvements resulting in steady increases in the accuracy of decisions. These initiatives and others have positioned VBA to achieve historical record-breaking production and quality in service to Veterans, their families and Survivors.

Prior to joining VA, Ms. Hickey led a Human Capital Management program at Accenture for the intelligence community, including the National Geospatial Intelligence Agency, where she supported operational business processes in the areas of customer relationship management, call center practices, and 21st century information technology systems.

Under Secretary Hickey served 27 years in the United States Air Force on Active Duty, in the Air National Guard, and in the Air Force Reserve, retiring with the rank of Brigadier General as the Director of the Air Force's Future Total Force office at the Pentagon. In this role, she was responsible for shifting billions of dollars toward new capabilities across the Air Force portfolio and directing new organizational models for a worldwide, 500,000-person organization. Under Secretary Hickey is a 1980 graduate of the U.S. Air Force Academy, the first class to include women.

Department of Veterans Affairs

Senior Executive Biography

Mr. Stephen Warren

Executive in Charge and Chief Information Officer
Office of Information and Technology

Mr. Stephen Warren joined the Department of Veterans Affairs in May 2007 as the first Principal Deputy Assistant Secretary (PDAS) in the Office of Information and Technology (O&IT) and currently serves as the Executive in Charge and Chief Information Officer for OI&T. In this role, Mr. Warren oversees the day-to-day activities of VA's $3.7 billion IT budget and over 8,000 IT employees to ensure that the VA has the IT tools and services needed to support our Nation's Veterans. Mr. Warren has successfully led the consolidation of VA's vast IT network into one of the largest consolidated IT organizations in the world.

Mr. Warren has over 30 years of federal experience. Previously, Mr. Warren served as the Chief Information Officer (CIO) at the Federal Trade Commission, joining in December 2001. Among other accomplishments at the FTC, Mr. Warren managed the successful implementation of the Commission's National Do Not Call Registry in 2003. Prior to the FTC, Mr. Warren served for ten years at the Department of Energy (DOE). His last position at DOE was as the CIO for the Office of Environmental Management, a $6 billion per year program responsible for managing the clean-up of former nuclear weapon production sites. Before working at DOE, Mr. Warren served for nine years on active duty in the Air Force where he was involved in a broad range of activities including: research in support of the Strategic Defense Initiative (SDI), support for nuclear treaty monitoring efforts, and service in Korea as a transportation squadron section commander.

Mr. Warren is a 1982 graduate of the University of Michigan, where he received a B.S. in Nuclear Engineering. He received a M.S. in Systems Management from the Florida Institute of Technology. He is widely published on subjects involving nuclear facilities, radioactivity, and related issues. He is an accomplished speaker on a range of topics including information security, project management, and managing change.

Mr. Warren was recognized by Federal Computer Week as one of the Federal 100 award winners for 2012 and 2004. He received the Presidential Rank Award of Distinguished Executive in 2008. He is a recipient of the 2006 Government Information Security Leadership Award (GISLA). In 2004, Mr. Warren was awarded the Service to America Social Services Medal, as one of the managers of the FTC's National Do Not Call registry. He led the IT team that received the 2004 AFFIRM (Association for Federal Information Resources Management) Leadership Award for Innovative Applications and one of five federal 2004 American Council for Technology Intergovernmental Solutions awards. He is a founding member of the CIO Executive Council, and a member of the CIO Executive Council Advisor Board.

Department of Veterans Affairs

Senior Executive Biography

Helen Tierney, MPM, MS

Assistant Secretary for Management and Chief Financial Officer, Office of Management

Helen Tierney was appointed as the Assistant Secretary, Office of Management at the Department of Veterans Affairs on June 24, 2014. She was confirmed as the Chief Financial Officer on December 16, 2014.

Ms. Tierney oversees VA's budget and financial management as well as the Department's performance management, business oversight, enterprise risk management, and asset enterprise management programs. Immediately prior to this appointment, she served as the Executive in Charge for the Office of Management. Ms. Tierney joined VA in March 2011 as the Executive Director for Operations in the Office of Management.

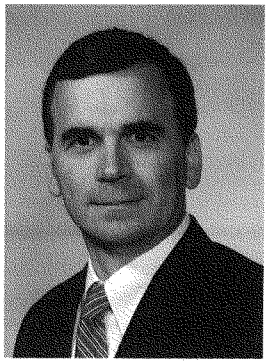
Prior to joining VA, Ms. Tierney served in the Department of Homeland Security (DHS) as the Executive Director for Planning, Program Analysis, and Evaluation for the Office of Field Operations in the U.S. Customs and Border Protection Agency. Before her appointment in DHS, Ms. Tierney served in Army civilian positions in Germany, Italy, Korea, and in the U.S.

Ms. Tierney holds a Bachelor of Arts degree in Government from Cornell University; a Master of Policy Management degree from the Public Policy Institute (now the McCourt School of Public Policy), Georgetown University; and a Master of Science in National Resource Strategy from the National Defense University, Industrial College of the Armed Forces (now the Dwight D. Eisenhower School for National Security and Resource Strategy).

VA | U.S. Department of Veterans Affairs

National Cemetery Administration

GLENN R. POWERS
DEPUTY UNDER SECRETARY
FOR FIELD PROGRAMS
WASHINGTON, DC



Glenn R. Powers was named Deputy Under Secretary for Field Programs March 10, 2011. In this position, he is directly responsible for the operation of 131 national cemeteries nationwide and all of NCA's memorial programs. He previously served as Acting Director of Field Programs from January 2011 to March 2011 and Acting Associate Director of Field Programs from June 2010 to January 2011.

Mr. Powers' joined NCA Sept. 17, 2006, as the Director of NCA's Memorial Service Network (MSN) IV in Indianapolis where he managed the operation of 27 national cemeteries in nine states.

A career infantry officer, Mr. Powers is Airborne, Air Assault and Ranger qualified and has been awarded the Combat Infantryman's Badge for participation in Operation Just Cause as an Infantry Battalion Adjutant in the 7th Infantry Division (Light) and Operation Enduring Freedom as an Infantry Battalion Executive Officer in the 101st Airborne Division (Air Assault.).

Prior to his retirement from the Army in 2006 at the rank of Lieutenant Colonel, he held various command and staff positions at Fort Ord, Calif.; Schofield Barracks, Hawaii and Fort Campbell, Ky. Mr. Powers is a 1986 graduate of the U.S. Military Academy (USMA) at West Point, N.Y. , and when not serving in Infantry assignments, he was involved in the development of future leaders while on the staff and faculty at USMA. The final assignment of his Army carreer was as Professor of Military Science and Battalion Commander for the U.S. Army ROTC unit located at Indiana University-Purdue University Indianapolis.

Mr. Powers holds a Master of Arts degree in Geography from the University of North Carolina, Chapel Hill. He is a graduate of the Veterans Health Administration's Health Care Leadership Institute (ECF Members), the Federal Executive Institute's Leadership for a Democratic Society, the VA's Senior Executive Service Candidate Development Program, and Leadership VA.

THE CHOICE ACT

Mr. DENT. Thank you, Mr. Secretary. Mr. Secretary, I have to begin with an issue I view as critical to the future of the V.A., and we have discussed this. And I know this view is shared with members of the subcommittee.

The Choice Act, as you know, is bifurcated, reflecting the different views of the members of the House and Senate authorizing committees at the time. On the one hand, the Choice Act sets up a system for non-V.A. care to be provided in situations where distance or wait time prevent access to direct V.A. health care.

But it also finances a hiring of almost 10,000 new V.A. medical staff, and more than 200 facility leases and construction projects in an effort to strengthen capacity for direct V.A. care. This is a rhetorical question, but is this bifurcated system sustainable in the long term? Can we afford to build up the V.A. system with its aging infrastructure, at the same time as we develop non-V.A. care alternatives?

I personally think that non-V.A. care is a great and underutilized alternative, particularly in the aftermath of what happened in Phoenix and elsewhere around the country. Many veterans have high-quality, non-V.A. facilities in their neighborhoods, but aren't able to use them, and instead have to travel great distances for V.A. care.

Let me be clear, I understand and support the need for the V.A. to provide specialty services in areas like polytrauma injury, PTSD, TBI, Agent Orange, behavioral health, and other areas. But why shouldn't we rely on high-quality, private-sector providers for more routine, non-service-related care?

That is really my question. And for you, Mr. Secretary, given where I live and many members live, we have some world-class facilities that just really cannot be utilized by many of our nation's veterans who deserve the best.

Mr. MCDONALD. Mr. Chairman, we share your vision for hybrid or integrated system of the future, an integrated system of V.A. care and non-V.A. care. Looking at it from the veterans' perspective, we want the veteran to get the care they need, wherever it is most convenient and that care is available.

Outside care is something the V.A. has been about for quite a while. In fact, over the last year, our non-V.A. care appointments have increased about 48 percent. So that is a large increase. That is even before the Choice Act.

With the Choice Act, we now have the ability, as you said, if you are outside 40 miles, if you are beyond 30 days of getting more people access to outside care. It is very early in the days of the Choice Act. The last cards were mailed in January. We started in November.

We set up the program in a period of months. And so we are not yet certain how many veterans will take advantage of the Choice Act. And we would like to continue opening the aperture of the Choice Act so more veterans can take advantage of it.

We are now getting in contact with all veterans to make sure they are aware of it, since many of the cards were sent out over the holidays, and may have been lost. We are also airing a public

service ad, which is on our web-site, and we would be happy to share that ad with you. And we are doing everything we can to get more providers into the system.

But so far, we have not seen the full impact of the Choice Act. And we want to work with you on redefining it in order to get more people into it.

Mr. DENT. In my observation, is many veterans are aware of the program, but for whatever reasons, they are not eligible; either they don't meet the 40-mile requirement, or a scheduling issue. But as a quick follow up, would the idea of a mix, or integration of the V.A. in private sector, could that help us to address the facility challenges that you so clearly articulated in your testimony? Would this help us predict where veterans will be geographically in order to build the facilities years in advance?

Mr. MCDONALD. We think it will. If you look over our recent past, we have been leasing more facilities and creating more community-based outpatient clinics than we have the big, large hospitals. That is a trend in the medical industry. And it is one that we think is appropriate in order to get care out to where the veterans actually live.

RESTRUCTURING V.A. HEALTH CARE

Mr. DENT. And I would also mention, too, last week a group, Concerned Veterans for America, released a report called "Fixing Veterans Health Care." The report prescribes a major restructuring of the V.A. health care.

Among its proposals, this bipartisan task force recommends that future veterans be required to enter a new V.A. insurance system with varying levels of coverage. Currently-enrolled veterans would be able to continue using V.A. health facilities, or shift to subsidized care to private providers.

It also calls for the closure of inefficient V.A. medical facilities similar to your testimony. Mr. Secretary, I know you issued a statement rejecting the report saying that, "Although there is an important role for non-V.A. care in supplementing V.A. health care, reform cannot be achieved by dismantling the V.A. system or preventing veterans from receiving V.A. care."

I am certainly not endorsing the report in its entirety, but I do think it could jumpstart a healthy debate about how to more efficiently and cost-effectively provide care to veterans. I would be curious about your thoughts.

Mr. MCDONALD. Well, as you said in the statement that I issued, we felt that many of the proposals advocated contracting out this sacred mission that we have for care for those who have borne the battle. We think there is an important role for outside care, as I have said. We think there will be a hybrid system, an integrated system in the future, to supplement V.A.'s own care.

But we don't think that diminishes or obscures the importance of V.A.'s health care system. We think reforming V.A. health care can't be achieved by dismantling it and preventing it, or preventing veterans from receiving the specialized care and services that can be provided by V.A.

Our goal continues to be to provide that care for veterans, and we are happy to meet with anyone to discuss any ideas. We believe

every idea is on the table. But we are going to look at it through the lens of what is best for veterans.

Mr. DENT. Thank you. My time is expired. I would like to recognize the very distinguished ranking member.

Mr. BISHOP. Thank you very much, Mr. Chairman. At this time, Mr. Farr, he is ranking member of the Agriculture Subcommittee, and he has a hearing that he needs to be in presently. So I am going to yield to him, and allow him to go first.

Mr. FARR. Thank you very much for yielding, Mr. Bishop. And thank you, Mr. Chairman. Thank you very much, Mr. Secretary, for coming here. And thank you for your service. You know, the most frequently asked question in Congress is "why don't we run government like a business?"

I don't think anybody has come before this committee with more business background than you have; CEO and President of Procter & Gamble, which was awarded the best company for developing leader talent. The list goes on and on.

Also, I think your training in the military in the 82nd Airborne and in jungle warfare is going to be very helpful. You are coming before a Congress, which has just told you that despite this incredible testimony with probably more reform and suggestion in it than any opening statement I have ever heard from a secretary in any department, that you are not going to get the money you are after.

I hope, Mr. Chairman, when we finally get these numbers, and we are taking the Veterans' budget and cutting and squeezing and trimming it, we can bring the Secretary back and have a real, transparent discussion on what those cuts are going to mean and what is going to happen as a result. Mr. Secretary, you put in here how we can fix the things that are broken, you also indicate that you are going to need money to do that. It can't all be done just by savings. For example, I think your idea of a "BRAC for veterans facilities" may be worth looking into but endeavors like that cost money.

Also I want to tell you that I appreciate you going out and seeing cemeteries, as you have. A week from Friday, I am dedicating the California Central Coast Veterans Cemetery in my district. Your department has been very helpful in its creation and I wanted to thank those in your department who worked in that.

HEALTH CARE ACCREDITATION

You indicated in one of the Chairman's questions about some sort of combined professional network involving the public and private sector that could help provide more mental health practitioners. I am very concerned that because of PTSD TBI, and other mental health issues, our veterans in California are suffering unnecessarily due to a shortage of appropriate doctors. I know that Congresswoman Barbara Lee is very concerned about this, too. We can't find marriage and family therapists to work for the V.A. because the V.A. has an accreditation issue in California. I really want you to go back and find out what initiated the ruling on this issue. We can't hire marriage and family therapists in the V.A. unless they have graduated from institutions that have specific accreditation curriculum.

California has 95 percent of certified marriage and family therapists who cannot qualify to work for the V.A. They went to Stanford, they went to Berkeley. I mean, this is nuts. I can't believe that they can't take steps to correct that.

We are opening the first jointly designed DOD/V.A. clinic on the Monterey peninsula, next year and we are having a heck of a problem trying to hire a psychiatrist to come there. You are having even a harder time getting marriage and family therapists. A lot of them in the community would love to go work for the V.A. I hope that you will check what steps the V.A. is taking in providing and maintaining a significant number of mental health practitioners.

When can you accept the credentialing of California marriage and family therapists as part of that professional core that you want to increase?

Let me also ask you to look into the backlog with the board of appeals. Mr. Secretary, the amount of money you are committing to that is going to be cut, in these reductions the chair is talking about. He is not the only chair—every chair of every appropriations committee is giving the warning, Mr. Secretary. What we do here is, we have all these nice hearings on what the President has proposed. Then we get the numbers from the Budget Committee. And then we go behind closed doors, and cut the hell out of everything. Then we adopt it without any public transparency. I hope this year will change that, and that we have subsequent hearings once we get the numbers, saying "this is what you are asking", "this is what you are going to get."

What are the consequences? Because that is what we are supposed to relay to our constituents. So, if you could look into the marriage and family counseling and the backlog on the board of appeals, I would appreciate it.

LOCAL COMMUNITY SUPPORT

Lastly, let me just ask, if local law enforcement officers are coming to me and they say that the V.A. needs to assist local law enforcement officers and VSOs in dealing with suicidal veterans who should they contact to help these people that they know from the local community are in harms' way? There is no kind of crisis core in the V.A. who can go out with law enforcement and intervene in these crises with veterans, who have real problems. I would like to see if we could develop that enterprise. Thank you.

Mr. DENT. Would you like to respond quickly, Mr. Secretary?

Mr. MCDONALD. Yes, sir.

First of all, relative to our employment initiative, we are recruiting. This week I was at the University of Delaware School of Nursing, and it was my 13th medical school trying to recruit people. So we do desperately need people.

We talked about the issue in California. I would ask Dr. Clancy to do a deep dive on that. Maybe let her report on that.

Dr. CLANCY. So, thank you, Mr. Secretary. Congressman, we have a group taking a very hard look at this again. You have the facts exactly right, in terms of our initial interest in hiring marriage and family therapists who have graduated from an accredited program by a commission with a very long name, because we wanted to make sure that we had people with the best skills to meet

the needs of veterans, which can be fairly complex. My understanding is that some of the newer programs have actually sought that accreditation. But we would be happy to follow up in terms of looking at other opportunities for us to bring this cadre of folks in to help veterans.

Mr. MCDONALD. Relative to the peace organizations, we do have a national peace organization, well trained to deal with veterans, particularly those with traumatic brain injury. It is their role to reach out to the community, connect with the community, make sure that the local community is aligned.

Mr. FARR. What they need when the crisis occurs, is to have somebody they can call who knows the veterans. Local law enforcement can't always talk them out of a situation.

Mr. MCDONALD. Absolutely. We will follow up on that. We are working very hard to strengthen our security organization, particularly in light of what happened in El Paso, and this will be one of the things we build into it.

Mr. FARR. Thank you.

Mr. DENT. Thank you. At this time, I would like to recognize Mr. Jolly, of Florida.

Mr. JOLLY. Thank you, Mr. Chairman. Mr. Secretary, thank you for being here this morning.

I have a couple quick questions, specifically on appropriations matters.

CLAIMS BACKLOG

You and I spoke about the backlog in benefits; it is a priority of mine. And I think the next story after the V.A. is going to be the VBA if we don't solve the backlog.

Your budget requests $85 million, for 770 new FTEs, as well as $230 million additional for I.T., sorry, an addtional $85 million. Mr. Secretary, do you believe that will have a demonstrable impact on clearing the backlog, or are we just keeping up, as best we can?

Mr. MCDONALD. I think we will have a demonstrable impact. And, as we talked, the number of claims is going up. The number of issues per claim is going up. We have committed to ending the backlog by 2015 and then keeping it down. I would draw your attention to the pictures in my written testimony of the Winston Salem VBA office, where on one picture, you see all the files that Chairman Rogers was talking about. The other picture, you see no files. Because everything has been digitized.

We have done all we can with digitization, with mandatory overtime. Now, we need more people.

Mr. JOLLY. And ending the backlog is defined how?

Mr. MCDONALD. 125 days.

Ms. HICKEY. So, I just wanted to let you know, Congressman, that actually, we are well on target to end the disability rating claims back on the 125 days. We are—right now, we have reduced that backlog from 611,000 down to 214,000—almost 400,000 that are no longer in backlog.

We also have at the same time increased the quality of our claims. Well over 90 percent on the medical issues level and 96 percent on—90 percent claim level, 96 percent at the medical issue

level. We will do that. But your question is about the current budget.

The current budget is focused on the appeals, non-rating and fiduciary requirements. Those are all direct results of doing 1.32 million claims.

OFFICE OF INSPECTOR GENERAL'S FY 2016 BUDGET REQUEST

Mr. JOLLY. Well, I understand. And I appreciate your attention to this. Quite frankly, it was something that I would support; this is an issue of significant concern. Very quickly, on the OIG budget, what is the increase in the OIG budget?

Mr. MCDONALD. The increase that was in the——

Mr. JOLLY. Request.

Mr. MCDONALD [continuing]. The real request—we have had subsequent conversations with the OIG—is $15 million. We support that request.

[CLERK'S NOTE: The official request is $355,000 above FY 2015.]

Mr. JOLLY. What percentage is that?

Mr. MCDONALD. I don't know exactly.

Mr. JOLLY. Is the increase in the OIG budget comparable to the 7.5 percent increase in the overall VA discretionary request? Is it less?

Mr. MCDONALD. We will do the math and get back to you. It is $15 million. We have a lot of investigations going on and we need to get through them, get them over with.

VA Response: If you compare between FY 2016 Request plus the additional $15M for OIG the Secretary requested during the hearing's testimony, then the percentage increase from the FY 2015 Enacted level is 12.15%.

	FY 2014 Actuals	FY 2015 PB Request	FY 2015 Enacted	FY 2016 Request	% increase FY 2015 Enacted to FY 2016 Req	FY 2016 Req + $15M	% increase FY 2015 Enacted to FY 2016 Req
OIG	121,411	121,411	126,411	126,766	0.28%	141,766	12.15%

If you compare between FY 2016 Request plus the additional $15M to the FY 2015 President's Request, then the percentage increase is 16.77%

	FY 2014 Actuals	FY 2015 PB Request	FY 2015 Enacted	FY 2016 Request	% increase FY 2015 Req to FY 2016 Req	FY 2016 Req + $15M	% increase FY 2015 Req to FY 2016 Req
OIG	121,411	121,411	126,411	126,766	4.41%	141,766	16.77%

NOTE: FY 2015 Enacted was signed into law Dec. 16th after the OMB Passback

COMMUNITY MENTAL HEALTH PARTNERSHIP

Mr. JOLLY. Another appropriations question—fisal year 2014, there was a request for the department to pursue community mental health partnerships. To use excess capacity in major metro areas to provide non-V.A. mental health services. Has there been any movement on that?

Mr. MCDONALD. There has been a significant movement. In fact, I will let Carolyn talk about it. I wanted to mention something you and I had talked about earlier—strategic partnerships. Home-Base, in Boston where I visited, funded by the Boston Red Sox. Serving veterans with TBI, with PTSD. We are very supportive of activity. We want to create more of this strategic partnership.

Dr. CLANCY. So, we do actually actively partner with a number of practitioners in the private sector to help serve the needs of veterans. And the good news is, we just learned that we have figured out how to make sure that they have easy access to our continuing education materials. Rather than our kind of shipping them in paper, now they can actually get online directly and get their continuing education credits, which I think only strengthens them.

Mr. JOLLY. The 2014 bill directive actually provides for a demonstration project. Is there anything—have you actually defined a demonstration project in this? Or are you just using non-V.A. providers when you need them?

Dr. CLANCY. I think that we have done some of both, but I am going to have to follow up with you on that one.

The Department of Veterans Affairs (VA) has pursued enhanced partnerships with community mental health providers. Twenty-four pilot partnership programs across nine states and seven Veterans Integrated Service Networks (VISNs) were established to strengthen partnerships between VA and community providers. The pilots were established across Georgia, Tennessee, Wisconsin, Mississippi, Alaska, South Dakota, Nebraska, Indiana, and Iowa. Pilot programs varied and included provisions for inpatient, residential, and outpatient mental health and substance abuse services. The Department of Health and Human Services (HHS) assisted VA in identifying community providers to support these pilot programs. Sites were established based upon community providers' available capacity, levels of care available, Veteran preference for non-VA care, location of care with respect to Veteran population, and mental health needs in specific areas. These Community Mental Health (CMH) partnership pilots were initially developed after the issuance of Executive Order 13625 in 2012.

The CMH pilots were approved and funded for a 12-month period. VA negotiated each site and partnership agreement on an individual basis; therefore, there was no uniform start and end date. All pilots were initiated between January 15, 2013, and May 31, 2013, in accordance with an established time line.

The Office of Mental Health Operations Program Evaluation and Resource Center (PERC) was tasked with conducting an evaluation of clinical outcomes, Veteran satisfaction, and project implementation to evaluate the quality and efficiency of this pilot initiative. The results of this evaluation will help guide clinical operations and policy development regarding VA-CMH partnerships. For the outcome survey, trained call center staff contacted eligible Veterans by telephone for baseline assessment within six weeks of a Veteran's referral to a VA-CMH partnership. All Veterans were re-contacted for a follow-up assessment three to five months after their referral. A portion of Veterans were only assessed once retrospectively, three to twelve months after referral. The assessment is a structured interview about current mental health symptoms, their impact on a Veteran's functioning, and experience with the VA-CMH partnership. Data on outcomes and treatment satisfaction was collected by the end of FY 2014. VA will complete national and site-specific reports by the end of the first quarter of FY 2015. Per the specified FY 2014 Conference report direction regarding metrics, reductions in access time to treatment and in symptom levels for substance abuse and related behavioral conditions are being evaluated. The pilot partnership programs were not specifically designed to evaluate reductions in readmission rates or improve linkages to employment and housing services; however, readmission rates and access to employment and housing services are tracked by every VA facility.

Additionally, the VA mental health program offices asked their Program Evaluation Resource Center to conduct a qualitative implementation evaluation across all of the pilot partnership programs. Drawing on interviews with key staff and analysis of memoranda of agreement, contracts, and other documents created as part of the pilot program, the evaluation describes the successes and challenges associated with this program. The evaluation focused on: how roles and responsibilities were determined between VA and partner sites; barriers faced in setting up programs; challenges in

ensuring delivery of coordinated care; how high quality of care was assured; and how, if at all, the manner of service delivery affected program formation and implementation. The qualitative evaluation report has been drafted and will be finalized by end of the first quarter of FY 2015 .

VA will be happy to share the results of the evaluations with the Committees to help further the shared goal of ensuring coordination of mental health care between VA and community providers.

The table below lists the 24 pilot program sites, the associated VA Medical Center, the community provider that participated in the pilot, and the ending date of each pilot.

Table 1. Community Mental Health Pilot Sites, Associated VAMCs

	Geographic Location	VAMC	Community Provider	12-month End Date
1	Griffin, Georgia	Atlanta VAMC	McIntosh Trail Community Service Board (CSB)	Feb. 2014
2	Flowery Branch, Georgia		Avita Community Partners	Feb. 2014
3	Atlanta, Georgia		Peachford Behavioral Health System	March 2014
4	Atlanta, Georgia		DeKalb Community Service Board (CSB)	May 2014
5	Canton, Georgia		Highland Rivers Community Service Board (CSB)	May 2014
6	Lawrenceville, Georgia		View Point Health	May 2014
7	Newport, Tennessee	James H. Quillen VAMC, Mountain Home, TN	Cherokee Health Systems	Feb. 2014
8	Mountain City, Tennessee		Frontier Health	May 2014
9	Bedford, Indiana	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc. (ASPIN)	May 2014
10	Columbus, Indiana	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc. (ASPIN)	May 2014
11	Kokomo, Indiana	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc. (ASPIN)	May 2014
12	Cashton,	Tomah VAMC	Scenic Bluffs Health Center	Feb. 2014

	Geographic Location	VAMC	Community Provider	12-month End Date
	Wisconsin			
13	Bolivar County, Mississippi	G. V. (Sonny) Montgomery VAMC, Jackson, MS	Delta Community Mental Health Services (DCMHS)	Feb. 2014
14	Gulfport/ Coastal Mississippi	VA Gulf Coast Veterans Health Care System, Biloxi, MS	Gulf Coast Community Mental Health Clinic	Feb. 2014
15	Wrangall, Alaska	Alaska VA Healthcare System	Alaska Island Community Services (AICS)	May 2014
16	Southeastern Alaska	Alaska VA Healthcare System	South East Alaska Regional Health Consortium (SEARHC) Behavioral Health Department	May 2014
17	Huron, South Dakota	Sioux Falls VA Health Care System	Community Counseling Services	Feb. 2014
18	Sioux Falls, South Dakota	Sioux Falls VA Health Care System	Southeastern Behavioral Health Care	Feb. 2014
19	Mitchell, South Dakota	Sioux Falls VA Health Care System	Dakota Counseling Institute	March 2014
20	Cedar Rapids, Iowa	Iowa City VA Health Care System	Abbe Center for Community Mental Health	Feb. 2014
21	Des Moines, Iowa	Central Iowa VA Health Care System	Eyerly Ball Community Mental Health Center	Feb. 2014
22	Iowa City, Iowa	Iowa City VA Health Care System	Community Mental Health Center for Mid-Eastern Iowa	March 2014
23	Omaha, Nebraska	VA Nebraska-Western Iowa Health Care System	One World Community Health Center	Feb. 2014
24	Omaha, Nebraska	VA Nebraska-Western Iowa Health Care System	Charles Drew Health Center	March 2014

FALSE NOTIFICATION OF DEATH

Mr. JOLLY. And then one last thing just for the record. You and I spoke about this. I appreciate your attention to it. But I do want it to be on the record. We have had several cases of veterans and veteran beneficiaries, who have been notified falsely of their own death.

I understand from the V.A.'s perspective that it results from the Social Security Administration sending over a notice. We know it is disruptive to the veteran. The V.A. has always resolved it, but it is a disruption that takes a month or 2 to solve. So I would appreciate your continued attention.

Mr. MCDONALD. We actually talked this morning after our discussion, and we are going to go big into the Social Security Administration and find out what is going on. Because we have to take responsibility for that. The veterans are ours.

It is devastating.

Mr. JOLLY. Thank you for that. I appreciate it. Thank you, Mr. Chairman.

Mr. DENT. Thank you, Mr. Jolly. That reminds me of the old George Bernard Shaw statement that "the rumors of my death have been greatly exaggerated." Something we certainly don't want to have happen. Mr. Bishop.

VETERANS CLAIM INTAKE PROGRAM

Mr. BISHOP. Thank you very much, Mr. Secretary, Dr. Clancy, and the other panel members. Your fiscal year 2016 budget request includes $140.8 million for the Veterans Claim Intake Program, which is a continuation of a scanning program that began scanning in September of 2012.

I have a couple of questions about this. First, how many scanning contracts does the V.A. have for that program? And second, how many documents are scanned per month, and what happens to the documents after they are scanned? And then once the document has been scanned, how long does it take to get the completed package to a claims processor?

Mr. MCDONALD. Let me let Allison answer that, but I just want to say that the scanning process is absolutely essential. It allows us to digitize the claim, which allows us to have a national workflow. We can move those claims anywhere in the country that has time and effort to get it done. It is one of the things that has led to the reduction, the backlog. Allison?

Ms. HICKEY. So Mr. Ranking Member, first of all, one contract. It is a performance-based contract, so we have two large companies that participate in it. And they are rewarded for doing better. So there is a performance competition base there.

Four sites, one of which is in Newnan, Georgia, another in Kentucky, a third in Wisconsin, and a fourth in Iowa. We have successfully scanned more than 1.3 billion images since the start, at 99 percent quality. And that has effectively allowed us to reduce our paper inventory down to a remaining 25,000 claims out of the 477,000 in the inventory.

So we are 95 percent paperless right now. And we do all of our claims works now in the digital environment, minus those 25,000 we are trying to get out. The companies have done a very good job of building quality assurance into this. We have mandated that for the contract. They have four to five layers of quality assurance to ensure the reliability.

But to the point of what happens to the paper? We are paying a lot of money for the contractors to hold the paper while they are waiting on the DOD decision, because these are DOD records. We are working actively with DOD to the Benefits Executive Committee to make that decision. We will be involving our veteran service organizations in that final decision on what is the proper disposition of those records.

I will tell you that I have today, sitting in regional offices across the country, half a million cubic feet of paper we are no longer using or touching. We are waiting on the simple disposition decision on what to do with those paper records. Because we are doing most of our business through the electronic digital environment; in fact, more than a million claims, and more than 2 million rating decisions.

Mr. BISHOP. Thank you. So when do you think that decision will come?

Ms. HICKEY. So Congressman, I am going to try to talk a little quieter. I apologize. My good Irish voice carries loud.

So we are working literally right now on a decision with DOD. They are newly incentivized to move faster on this issue, because they are now storing paper from what they are scanning in their central cells for the services to bring us the records across from HAIMS.

So we are literally right now, as we are working, I suspect sometime this year we will have a final decision. When we do, that will, as I expect, require resources to move us into that environment of proper disposition of those records. And that is not in the current budget right now.

V.A. AND DOD INTEROPERABILITY

Mr. BISHOP. All right. I recently read that VistA is no longer in contention to use by DOD for the electronic health records, which is not surprising, because it was clear that DOD historically has wanted nothing to do with VistA. What steps are being taken to make sure that whatever system that DOD chooses, this will be able to share information with it?

I know that this is well before your time, Mr. Secretary. But as you know, the veterans department and DOD were directed to develop an electronic health record system. And can you tell us why it has been so difficult to achieve?

Mr. MCDONALD. Ranking Member Bishop, I have said many times since I came in this job that we shouldn't punish veterans or servicemembers by having boundaries between organizations that get in the way of their care.

So we take it very seriously that we have got to integrate with DOD on the electronic health record. It is one of the first things I looked at. And I have been to our sites, San Antonio, for example,

where we run a hospital with DOD, and we have V.A. and DOD doctors looking at the same medical information on the screen.

So I would like Steph Warren, if I could, to do a little bit of a deep dive on this, to bring the committee up to speed. And we would be happy to come over and do demonstrations for you in your office for your staff.

Mr. WARREN. So to hit your point about interoperability, top question was with whatever system DOD purchases, is interoperability guaranteed?

DOD, no matter what system is bought, the requirement to maintain the interoperability that we have accomplished will continue. So we talked in prior hearings about a tool called Janus, which today, allows us to look at the DOD record and the V.A. record in the same screen simultaneously. So that interoperability, the ability to see the record in the care setting is happening today.

Mr. BISHOP. May I just interrupt you for a second? Didn't we in Congress, both the authorizers and the appropriators, direct DOD and V.A. to use one system, as opposed to two systems?

Mr. WARREN. So the interoperability in terms of the information sharing and doing, we are doing that using the same services. Both of the departments approximately 2 years ago—and I believe we had a joint hearing. I think it was the largest hearing I had ever been in, with 50-plus members.

We talked through how the mission differs between V.A. and DOD and drove DOD to a decision in terms of buying an end-to-end system with a logistics tail, and that we would continue to work with the VistA system, which is a veteran-centric solution, and keep evolving it forward.

Mr. BISHOP. It is my understanding, though, that the system that you are using prohibits the manipulation of the data. So basically, it is viewing only. So it is not really interoperable, because, you know, a doctor at V.A. can't manipulate the information there, so that is not very helpful in what we are trying to get to. And we really instructed both DOD and V.A. to have one seamless system.

And of course, this was before the Secretary's tenure, both departments seemed to have backed off from that and just said, "Well, we wanted interoperability."

But it just makes no sense to me. And I have continued to really labor over the question of why it is that DOD and V.A. want to have stovepipe systems that is just going to allow them to view it.

Mr. WARREN. If I could, the viewer is to show the ability to view the data. There is a key point that we need to make sure we lay out there.

If you look at the DOD side with respect to care, the majority of their care takes place outside of their health care delivery system—it will also take care of—it will be given outside of whatever their new system is.

On the V.A. side, with the third-party care we have been giving, as well as what the Choice Act will be doing, a large amount of our care will also be outside of that health care system. Our biggest challenge is how do you move the data between different systems? How do you present it up in a care setting?

Janus shows that you can do it. The data gets translated so it is the same. All Janus did was to show that you could do it, yes,

in a read-only. Right now, the enterprise health management program, which is—in San Diego, moves it to the next step, which is the ability to go in—

Mr. BISHOP. Why couldn't both departments have one system? And if you have outside care, have the outside providers certify it to utilize and to enter that system with secured access so that only people who are authorized can enter the system? But if you have one system, everybody is going to access. It is simple.

Mr. WARREN. Sir, I wish it was that simple. When we talk about health care delivery, the viewer is how the clinicians interact with the data. But the systems we are talking about are more than just the viewing of the data. It is the pharmacy system, it is the immunization system, it is all of the other——

Mr. BISHOP. I understand that.

Mr. WARREN [continuing]. A medical center.

Mr. BISHOP. I understand that.

Mr. WARREN. So buying one big system that does all that stuff, if you go look at the national health service in the U.K., they showed that one system could not do all that stuff across all those different places.

And so what is key is how do you make sure the data moves between the systems, not just V.A. and DOD—in a way that clinical care can take place. And I believe that is the path we are on, and we have been able to show that we can accomplish—but glad to come and sit down more, walk you through and show you how those systems are working together, and how the data is formed.

Mr. BISHOP. I am just not convinced that the technology can't be fashioned to accomplish that. But my time is up, and I will come back a little later.

Mr. DENT. Thank you. Thank you, Mr. Ranking Member. And I am sure there will be more questions on that particular topic. Mr. Rooney.

Mr. ROONEY. Thank you, Mr. Chairman.

I appreciate, Mr. Secretary, our visit yesterday. And I appreciate the spirit of the other testimony that we have heard. You know, it is okay if you speak too loud, especially with issues that frustrate not only members of this committee, your agency, as well as the veterans and the people that we serve. Certainly, South Central Florida has its share of retirees and veterans.

One of the things that I was most impressed with, Mr. Secretary, when we visited was the kind of background that you have, and the business acumen that you bring to the table. And I think that when people read your resume and get to know you, not to say that previous secretaries haven't been able to accomplish what they set out to do, but the fact of the matter is, we are still talking about a lot of the same things that we have been talking about since I got to Congress 6 years ago.

You know, as Mr. Bishop alludes to, one of the big frustrations for me, as a veteran myself, is when you join the Army and things are kind of prescribed for you, and you are sort of told where to stand, what to say and what to do, and then when you get out of the Army, and you kind of hear this, "Well, you know, the orders for the prescriptions aren't exactly the same," or, "We are just getting around to our computer systems being able to communicate

and understand each other," that is the kind of thing that when you join the Army, or you join one of the other branches, you assume are already taken care of. And when you find out that they are not, I think that that is the most frustrating thing.

FRUSTRATIONS AND FUTURE INNOVATION

So my question revolves around your background and some of the things and the frustrations that we have heard. You don't have a lot of time in this job, I assume. And what time you have here with being a former CEO of a major company, what do you honestly think that you are going to be able to accomplish for veterans? What kind of innovation?

I have a question, drafted out here for me about VSOs and our local counties that want to be able to be more active in screening, and things like that, at the county level. Maybe that is part of it. And you talked yesterday about, you know, consolidation of some of the people that are doing the same job. And that is all great.

But I think that you as a spokesman, getting out there and showing the kind of frustration that we have heard, the American people were responding to me like, "I like that guy. I agree with him. He is a CEO. He is not," you know, no disrespect again to former secretaries, but what can you—what has been your biggest frustration? What kind of innovation do you think you will be able to bring to the table so 6 years from now, this committee isn't still talking about these same things, like prescription orders aren't marrying up, and computers aren't talking to each other? So if you could talk to that, I would appreciate it.

Mr. MCDONALD. First of all, Congressman Rooney, thank you for the question, and thank you for your service. Everything we put together, we are not looking at as a time-bound exercise. But I would hope that everything we have talked to you about in terms of MyVA, the reorganization we are talking about, I think we can certainly get done over the next couple of years.

My biggest frustration from the very beginning was the lack of focus on the veteran. It was a sense that we were an organization, as I went around—and I have been to over 100 sites now of V.A.—employees were telling me they felt like they were prisoners of a system that they couldn't change.

The single message I am giving employees every time I go somewhere and I do a town-hall meeting is, "No, this is your V.A., too, and you can change it."

I have embraced union leadership, 65 percent of our employees are union members. This leadership team, this group of employees, is going to change the V.A., is going to put the veteran at the center of everything we do.

My first national press conference, which I think was in September, I gave out my cell phone number nationally. It is available on the Internet. And I would like members of Congress to do the same.

And I get calls every single day from veterans. And I like that, because I am able to figure out what is going on. We stood up a team of people to help me with it, but I like to answer the phone.

I did that deliberately, because I wanted to demonstrate to everybody during a time of crisis, it is normal organization dynamic, and

normal human dynamic, that people turn inward, and in a sense become more bureaucratic, and worry about their own survival.

What we need to do is turn outward, care about veterans, embrace veterans. And I see those changes happening right now. I hear it on my phone at night when I am able to answer the calls. And I get a lot of letters. And we respond to every single one of them. That is a big change.

Ms. HICKEY. So, Congressman, first thing I will ask you as a veteran, if you have your eBenefit account, if you don't, I would like to come over and help you get it. But you don't need me to, because we have built a complete online capability from a veteran at 2:00 in the morning, if you are reading a long bill, and you decide you want to file a claim, you can go online, you can file your claim online.

You can upload your own medical evidence online, and your three-and-one computer, turn it into a PDF and give it to us. You can find out the status of your claim online. And it all goes now into the VBMS system where the digitization has occurred that was spoken about earlier. And the decisions can be projected to you when they come out online.

All that has been built in the last 3 or 4 years while we have been transforming VBA. While I will fly on the airplane while we were building it—sorry, former airmen as well, so I am going to use that analogy. So we have fundamentally changed VBA already, but we are not done yet.

There are a lot of things in this budget that we need to fundamentally change three other parts of a benefit allowance to a veteran. And I will tell you straight up, appeals. Appeals are wired in law, worse than tax code.

There are two opportunities for you to help us with appeals. One is change the law, and there doesn't seem to be a lot of appetite for it. But I have submitted all the legislative proposals.

And the second is you have got to give me a whole lot more people to do that work. I have got no other way to do that better. Law or people, authorizers or appropriators. I don't care. What I care about is veterans getting a better answer.

Mr. ROONEY. Thank you.

Mr. DENT. Thank you. I just want to point out for the record, I made that particular quote about the rumors of my death being greatly exaggerated. I attributed it to George Bernard Shaw. I believe it was Mark Twain. So with that, I recognize Mr. Price.

Mr. PRICE. Thank you, Mr. Chairman. Mr. Secretary, I want to welcome you and your colleagues to the committee. We appreciate the energy and determination you have brought to the V.A. in a short period of time.

And I appreciate the background you bring to this; the business background, the military background, and I should say also the educational background, because I am well aware of the value you have rendered to Duke University's Fuqua School of Business, as one of their major advisers.

A lot of handwringing today, as there always is, about the constraints we are operating under. Maybe we need to remind ourselves that these are not written in stone. They are the results of very explicit political failings.

The Budget Control Act still hovers over us, and haunts the work of this subcommittee with its centerpiece of sequestration. Sequestration, however, is self-inflicted damage. It was not supposed to occur. It is the result of a very specific failure to address the main drivers of the deficit; tax expenditures and entitlement spending.

This body, having failed to address those, has fallen back again and again on appropriated spending. So we need to do more than just decry this, we need to change it, need to take specific steps to overcome it, that really would mean a comprehensive budget deal that deals with the main drivers of the deficit.

But if we can't get that, we at least need another year-long budget deal, à la Ryan-Murray, to get us off of sequestration and with some numbers we can work with here. And this applies of course to this subcommittee, and probably even more to other subcommittees.

So the resource constraints are serious here. And yet, a lot of the problems that you have identified call for additional resources, particularly personnel resources. And that is what I want to ask you about very specifically.

We are all aware of the unacceptable wait times for primary care, mental health, patients at various facilities in my district, around the country. We know that this is linked in part—this is what I want to ask you to assess—linked in part to a lack of primary and mental health care providers in the system, particularly at more rural locations.

So I want to give you a chance to address that problem systemwide. Is the lack of manpower, womanpower, a primary obstacle to achieving acceptable wait times, and adequate care in general? I know you visited a lot of medical schools, including Duke University, I would say. Glad you came there. You spoke to medical students about coming to work for the V.A.

HEALTH CARE STAFFING AND RECRUITMENT

How did you do? How are you doing? What can you do to recruit the best and brightest young people in the medical field? Where are the most serious shortages? What specialties, what areas of practice?

And then how much is this a matter of compensation? What else is going on here? What is your assessment, having looked at this, I know, very carefully? What is it going to take besides an adequate appropriation to solve the problem?

Mr. MCDONALD. Thank you, Congressman Price. Great questions. Staffing is a big issue for us. Roughly, we are short about 4,000 physicians and about 10,000 nurses.

I have been to roughly over a dozen medical schools. Duke University was the first medical school I visited. And we are competing against some of the for-profit systems in the country to attract the best and brightest doctors and nurses we can find.

One of the first things I did as Secretary was to raise the salary bands of our doctors in order to pay them competitively. That has helped our recruiting effort. And if I look over the last nine months, we have hired roughly 900 doctors, net-new.

So in other words, we have had some leave. Our retention rate is very good. We have had some leave. But we have got roughly 900

more new doctors. And that is good. We have hired over 1,000 nurses.

So that has been very helpful. But while getting the providers is helpful, and paying them competitively is helpful, the other thing I am up against is just in a sense the aura that exists in this country that V.A. is somehow a terrible place to work. And I am pleased that the Chairmen and Ranking Members of our two committees, House and Senate, Veterans Affairs committees, have come to V.A. We have town-hall meetings, national town-hall meetings, so that the members of the committee could express themselves to the employees about how much they respect what they are doing, and how important it is.

The other barrier we face is the infrastructure. We have 11.5 percent roughly female veterans right now. It is going to grow to 20 percent. And our buildings are over 50 years old. They were built at a time when you had one gender of bathroom, where you didn't have space for women's clinics. And one of the things we know about women veterans is they prefer to enter the building and exit the building in a different place than the men. So we are in the process of trying to retrofit those entries. But that is why our construction budget is so important.

One last example, and I will end, is part of the problem in Phoenix that we talked about was providers, was the doctors and nurses. When I went there, we needed 1,000 new people the day I was there. That was right after I was confirmed.

But one of the problems that didn't get much publicity, is we only had one clinical room for each doctor. And the average doctor has three clinical rooms; one where the patient is getting ready, one where the patient is being examined, one where the patient is getting ready to leave. So this is a fundamental issue.

Last point is, I talk a lot about V.A. being the canary in the coal mine for American medicine. Our shortage of primary care physicians, our shortage of mental health professionals, is a national shortage. And that is why I go to the medical schools, is to try to increase the throughput, and increase the residency, so we can get a greater number of mental health professionals and family care physicians.

Dr. CLANCY. Just a couple of other points, because I know that you expressed a particular interest in rural health care. One of the areas I think where we are doing very well is in virtual care, particularly telemental health, which frankly, makes it very—much, much easier for some veterans who don't always find any complex facility all that easy to navigate, and so forth.

We are doing enough of it that we are starting to talk now about whether we actually need to train and hire people who are virtualists. There are companies that do this now. We could actually have an internal group that does that.

The other part—and I just want to thank you and your colleagues for—is the loan reduction program. We now have, for the first time, the opportunity to pay the lenders back directly. What we have been doing before, if you think about how indebted many of these students emerge from post-graduate training with, is when they paid, then we reimbursed.

So if they fell behind, they didn't get the reimbursement. You can see where this gets into a kind of vicious cycle. Now we can pay the lender back. So not only can we offer that to new people coming in, we can actually help some of our own—it is both a recruitment and a retention tool, which I think is going to be phenomenal.

And ultimately, the mission is what really attracts people. You ask, though, what is the hardest? I would say primary care and mental health. Both, as you probably are aware, are not incredibly well-paid specialty areas. Both were in stiff competition with the private sector.

You probably saw the report yesterday from the Association of American Medical Colleges I think saying we are short 90,000 physicians or something along those lines. But that is what we are working at.

The point about spaces, we actually do have a tool now to assess productivity so that in addition to broad messages about we need space, people, and so forth, we can actually help facilities figure out what is the rate limiter for them. Is it really more the space, the people, and so forth?

Mrs. ROBY. Thank you, Mr. Chairman, and thank you for being here. I do want to echo the sentiment of my colleague, that we appreciate the time that you have taken to meet with us prior to today's hearing.

But I think a couple of the points that were discussed are worth mentioning again for the benefit of those that are in this hearing room today, and for the American people, and for my constituents in Alabama, too, who have suffered. These veterans have suffered horribly at the hands of bad actors.

Mr. Chairman, Central Alabama V.A. Health System is one of the worst in the country. We had one of the first directors actually removed under the new law that we passed because his behavior and the decisions that he made and the culture he created was so disastrous and horrible, that he was actually removed.

And you of course know all of this. And you are keenly aware of the situation. I appreciate Sloan Gibson, Deputy Secretary, for his presence in Alabama consistently working with my staff to provide us updates.

As I told you, Mr. Secretary, last evening, that I am looking forward to the day when I can stand with you behind the podium and celebrate the successes of the V.A. But we are not there, and you know that.

ACCESS TO CARE—THE CHOICE ACT

And there is still a real distrust, because the numbers that we were presented as it relates to access to care, were so false and wrong. So we will continue to work with you on that.

I do think, as you mentioned, that you are dealing with a huge bureaucracy, and feeling your way through it, that there are some real solid ideas here that you have heard from the chairman and others throughout this as it relates to access to care. And we know the V.A. does a lot more than just that. But for right now, we have a lot of sick veterans that need access to care.

And for me, in light of what took place in Southeast Alabama, I really want the focus to be down there on how do we get more

veterans access to good-quality care in a timely fashion, and both with Choice—the Choice cards and with PC3, Patient-Centered Community Care, which is a huge priority to me. We have wonderful private medical facilities in Southeast Alabama, where these veterans could access care immediately, rather than having to go to Atlanta, or some other facility.

So I want to continue to be helpful in any way that I can, to push these programs, that this committee could be helpful in ensuring that we allow veterans to have access to outside providers. And then we have all these aging facilities that need repair how do we figure out a way to find the cost savings in bricks and mortars, and use that money for our veterans to access care?

So I know these are all priorities of yours, because I have heard you say that. The one thing that I did want you to elaborate on is the authority to reallocate the Choice funding, as you have stated, that you have been mischaracterized on what your ideas are.

One thing I am concerned about is that Congress gave the VA $15 billion for Choice. And you were saying that there is uncertainty right now in knowing how much access veterans and how many veterans will utilize the Choice program.

So if we could just talk about that in a little bit more detail, because I really think that this is a huge part of the solution to getting towards this hybrid system that would allow our veterans to have good-quality health care.

Mr. MCDONALD. I was—one of my surprises when I came back to government was the inflexibility of being able to serve customers. I am used to the private sector. I am used to, if a customer wants to buy Tide, we have Tide for them. If they want to buy Dash or whatever, we have Dash for them.

The inflexibility of moving money from one line item to the other, despite the fact that the consumer, the veteran, has a choice, doesn't make much sense to me. It is analogous to having two checking accounts at home; one is for gasoline, one is for food. And you can't move money between the two. The price of gasoline falls in half, and you are hungry, you want to buy food. But you can't do that.

Because of the Choice program, we have given the veterans a choice. You, the Congress, have defined by law the benefits that veterans get. I am trained to execute and provide those benefits, but yet, you control both the benefits they get, and you control the money I have to spend to deliver those benefits. I am kind of a prisoner of the system.

All I was saying with the request for flexibility was—and I am happy to come back with you at the appropriate time—as these programs, as we begin to integrate these programs with the only intention of serving veterans, let's make sure we have a discussion that we have the money in the right place, and that we have enough money in the right place, that we can provide the veterans the care that the laws that we pass said they deserve.

I just want to make sure we have that conversation, because I can't predict the free market with 100 percent certainty.

40 MILES RULE

Mrs. ROBY. Sure, I appreciate that. Mr. Chairman, one quick thing about the 40-mile rule. I am concerned that the definition is not clear about the distance driving, or as the crow flies. What do we need to do to modify language so that we ensure that it truly is for those that are 40 miles away.

Mr. MCDONALD. When the law was passed, and the way the Congressional Budget Office scored it, it was 40 miles geodesic, meaning as the crow flies. We have been given enthusiastic support by both of our authorizing committees to take another look at that 40-mile criteria.

We are in the process of doing the review right now. We are going to come back to the Congress with a reinterpretation in an effort to open the aperture. We have had roughly a half a million calls to our call center about the Choice Act. But only—that has resulted in only about 30,000 appointments or so. And about half of those are because of 40 miles, about half of those are because of 30 days, the 30-day limit.

That is just not a big enough take rate. So we are trying to do a better job marketing. We are contacting veterans. We are also running a public-service ad I talked about. We want to see how far we can push it.

At the same time, we want to, as quickly as possible, redefine that 40-mile limit, which is the biggest barrier, and come back to members of Congress with that reinterpretation.

Mrs. ROBY. Okay, great. Thank you. I yield back. Thank you, Mr. Chairman.

Dr. CLANCY. Can I just add one thing? Congresswoman, I just wanted to thank you for your commitment to, and persistent attention to the Central Alabama facility. So today, our top analytics team is visiting with them, both helping them understand their data, which I think has been a big, big change for us, this relentless focus on how we are doing, and also how to deploy tools that we have built, so that they can identify some of the problems that occurred there at a much earlier stage. So just wanted you to know that.

Mr. DENT. I would like to recognize Ms. Lee at this time.

Ms. LEE. Thank you very much, Mr. Chairman. Good to see you, Mr. Secretary, Dr. Clancy, Secretary Hickey.

Now, I tell you, a couple of things—I have to preface the question and statement. First of all, I am the daughter of a veteran. My dad died several years ago. So as the daughter of a veteran, I know the V.A. system very personally. And I just want to say to the three of you that I think you made a lot of progress. I have had to deal with the V.A. on a personal basis.

OAKLAND REGIONAL OFFICE CLAIMS BACKLOG

But not enough yet. And I have a lot of concerns, very grave concerns regarding the funds that have already been spent on updating our veterans claims backlog. Again—and I think Secretary Hickey—we have met several times with the California Delegation as it relates to the Oakland V.A. Regional Office, which is in my district.

And we have seen money appropriated to fix the backlog. But it still remains—and veterans still, who deserve their benefits, they are still dying before they can receive their benefits.

And I want to read to you just a brief excerpt from—now this was February 25, 2014, just recently, CBS News report. Okay, and I want to make sure that this is accurate or not. I hope it is not.

"Last week, the V.A. Inspector General confirmed that because of poor recordkeeping in Oakland, veterans did not receive benefits to which they may have been entitled. How many veterans is not known, because thousands of records were missing when inspectors arrived. The V.A. declined CBS News' repeated interview request, but it did admit to widespread problems in the handling of claims, but blamed that on the transition from a mail basis to the new electronic system. The V.A. said in a statement, 'Electronic claims processing transformed mail management for compensation claims greatly minimizing any risk of delays due to loss and misplaced mail.'"

Now, there have been several whistleblowers, of course, out of Oakland. And in this report that CBS presented February 25th, there was one individual who said that the V.A. took the files, put them—told them to put them in a file and stuff them away.

There were 13,000 veterans begging for help. When this employee raised her concerns, she said she was taken off the project, and then this past summer, they found a cart of these same claims, and they were ignored again.

Can you explain this to me? Is this accurate or not? And what is taking place with the Oakland V.A. office in the backlog?

Ms. HICKEY. So I don't know what station Mr. Paul Harvey used to talk about. But there is a much bigger rest of the story that I would love to be able to present to you.

First of all, the 13,184 pieces of paper they found were duplicate copies of an informal claim. It isn't even a real claim yet. It is a duplicate copy of an informal claim. They were in an old process that used to be done in VBA long before I got here. They used to make copies of things to keep track of them.

And so those were the 13,184 pieces of paper put in the drawer. At the same time, those same 13,184 veterans came in with their formal original claim. We worked those all as they were coming in. They were not set aside.

Those 13,000 copies were sitting in a drawer. The originals were being worked by the employees, the hardworking employees in the Oakland Regional Office, or as you well know, because we have talked about this, many other hardworking employees across the nation who we brokered out, or sent out that work. So no, no veteran was waiting on those 13,184 while they were sitting in a drawer. That was a copy.

Second thing I would share with you is we did not misplace any of those 13,184. They were in that drawer. We brought in—we actually, by the way, discovered, because I sent in a help team to help Oakland. And when we found them, the employee did exactly the right thing; raise the issue and said, "There are 13,184 in there. We need to do something."

They told us about it. I called the I.G. and said, "Full transparency. I want you to get in there and make sure what is going on with those 13,184," and they did.

We set up special teams that took every one of those copies against the original file that we work—we had already worked. And we matched every single one twice, a full 100 percent review of every single one against those copies of those informal claims to make sure we had it right.

At the end of the day, we completed those two complete looks last September, on the 5th of September, and we found in the process of reviewing, there were about 403 to be exact, where we said, "You know what, we probably could have made a better decision on those 403 claims than we did when we worked them."

And so we made some adjustments. All of them are complete. None were missing. No malfeasance in that whole effort. No intention to hide anything. We just had those 13,000 copies over there.

That practice has been discontinued. That practice was not a practice by the new director who was out there, who is doing a terrific job. And today, Oakland, by the way, backlog is down 70 percent from when we were visiting when it was so bad in that same 2012-2013 time frame. They are doing much better. Their quality is up substantially. All the investments you helped us do to make them better are seeing good fruit.

Ms. LEE. I appreciate that. But then maybe you need to call CBS and clarify this, because this report is all over the place. Also, in it, it indicates that the V.A., the Inspector General, mind you, confirmed that because of poor recordkeeping, and Oakland veterans did not receive benefits to which they had been entitled, and this is the I.G. quote. So you need to clarify that I think, because if in fact that is not the case, you know, we need to know that. The I.G. needs to know that.

Ms. HICKEY. I think the I.G. has worked very hard on this. And I really appreciate their effort. They are looking at lots of things with us right now. And I think their point is well taken.

As you well know, we weren't doing a very good records-keeping job during that whole time where we were not in great shape in Oakland. I think that is exactly what they are pointing out to us, and the fact that we had a drawer of copies is still inappropriate, and not good recordkeeping.

We have resolved that. We have fixed that. So I think in this case, the I.G. was right. We shouldn't have had those copies just sitting out there in a drawer somewhere. We should have properly disposed of them when we were complete with the claim.

Ms. LEE. So do we know how many veterans should have been—should have received their benefits that did not receive their benefits?

Ms. HICKEY. Of the 13,184, all of them got their claims worked as we received them. When we did the reviews, we found about 400 where we went, "You know, we could have made a better decision there." But that is the 400 I am talking about.

Ms. LEE. Okay.

Ms. HICKEY. They had received a decision already, and they had received benefits already. We were able to up their benefits.

Ms. LEE. Okay. Thank you, Mr. Chairman.

Mr. DENT. Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, Mr. Chairman. Mr. Secretary, good morning. Welcome. Thank you all for your testimony this morning. I think it should point out, in light of all of the challenges and difficulties you are facing, Nebraska, by certain measures, has had one of the best outcomes for service to veterans, particularly in terms of the measure of process, time for processing claims.

I think we were one of the states that actually took on additional caseloads when other systems were under such severe stress. So I am proud of that. It doesn't diminish, though, the need obviously to continue to work aggressively across the nation. But to the degree that we have served as a valuable template, service delivery, we are happy to be in that position.

Mr. Secretary, I really do appreciate your freshness of approach, and your creative commitment to trying to rethink some of the architecture in order to get us all to the goal that we share; the highest and best quality of care for our veterans.

ENHANCED STRATEGIC PARTNERSHIPS

In that regard, I want to bring up a specific example from home. Omaha has a difficulty with our hospital, as you are quite aware. Over the years, based upon a priority list, which is not necessarily the list of funding priorities, but is listed as a priority, which is to me, a peculiarity. Nonetheless, it has floated from 30 down now to 10, 19, all over the place.

The broader point being to—maybe that is based on analytics, maybe that is based on more subjective criteria. I just don't know. The broader point, though, is enhanced strategic partnerships are the way forward. It is the model for the 21st century of veterans care.

If, as you are—have been invited, and as I know you are working to commit to coming to Omaha when you do, you will be warmly received by creative community partners who are ready and capable to think about, again, an enhanced strategy that looks at a new model by which we can build out a potential new facility, if that is what is necessarily decided upon, as long as we have the flexibility for creative financing, or using existing structures that could be rehabilitated, or partnering with the excellent medical facilities through the University of Nebraska Medical Center, a great medical center, another five facilities that are already there.

A quick anecdote, I have had the American Legion of Veterans of Foreign Wars in my office this week. And the committee has heard me talk about something, and you have as well, called "Veteran Certified Facility."

And what I think this does is give us the ability to carry forward this important legacy of having the V.A. in charge of veterans health care, but maybe embedding that within other systems, as long as we have oversight authority over us, so that the quality of care is delivered. But it gets us out of this problem of putting money under the mattress for years, sometimes decades at a time, in order to build out a facility, because we simply have been doing it that way for the last 100 years.

The next 100 years, though, we can take that money that we do have, leverage it in strategic partnerships, and assure the veteran

is getting the highest possible care, still while being under our authority. That is the new model and the way forward. I willingly commit our community to be your model template in this regard. I think—I don't think that is an overextension of the desires of the community that I represent.

But I would like to work with you, whether it means new legislative authority, or exercising the current authorities you have, or creating and enhancing those strategic partnerships, and labeling something like a veterans certified facility. I would like you to respond to that, please.

Mr. MCDONALD. Well, we agree with your comments. In fact, of the five objectives of MyVA, I think maybe perhaps one of the biggest ideas, other than being veteran-centric, is strategic partnerships. We are working very hard to establish strategic partnerships.

And when I say that, I include the community. And I would just point to the example of we have a problem with homelessness. We are trying to drive down homelessness to zero, virtual homelessness of veterans to zero by the end of this calendar year. Yet, we have had a lawsuit going on in Los Angeles for 4 years that stopped us from doing what we needed to do to use 380 acres that we had there for homeless veterans.

I got involved through a friend in Omaha. I found out who the law—who was behind the lawsuit.

We brought the community together, including the mayor and everyone else, and members of Congress. And we have come up with a solution and a memorandum of understanding, and a plan forward to eliminate homelessness. So, I want to do the same thing in Omaha.

Mr. FORTENBERRY. Perfect, Mr. Secretary, we need to get out of this trap of this priority list, which has, again, a model submitted a long time ago, but is not enhancing the opportunity to leverage the strategic partners and actually give the service that veterans need and in a quicker fashion.

We have got to eliminate this construct, because we are just carrying forward—as Sam Farr was saying earlier—we carry forward in time legacy systems—in Appropriations, somebody gets trapped into whether or not we are going to plus up the same system or cut it back, rather than creating new architecture that actually makes sense in terms of service delivery.

Does that mean my time is up? I didn't realize I talked that long.

Thank you, Mr. Chairman.

Mr. DENT. Thank you, and you did.

At this time I would like to recognize the gentleman from Ohio, Mr. Joyce.

Mr. JOYCE. Thank you, Mr. Chairman. You had just answered some of the questions I had and while I was listening to this discourse of other questions that were asked, I would like to follow up on the distinguished gentleman from Florida, Mr. Rooney's question about bringing your extensive business experience to the Department of Veterans Affairs.

What can Congress do to help you?

Mr. MCDONALD. I think the biggest thing Congress could do is provide me the flexibility a business leader has to get the job done.

Let's agree on what the task is. And then let's have the flexibility to get it done.

Budget line items, where money can't be moved in a free market economy. You know, arguably, the V.A. is the largest business in government. We are the second largest department in government. We are the largest health care system in government. At one time—and this goes back to the congressman's recent comment—many of the things that we do are archaic versus today. Today, veterans have choice. They never had choice before. Yet, our laws and our budgetary processes are all about an inflexible system, an inside system.

So, no criticism here. I just think we need to move forward and move toward the end game, which is going to be strategic partnerships. It is going to be a combination inside V.A. care and outside care. But we have to have the budget to do that. We have to have the flexibility to do that. And all of us focus on the task of providing the care to veterans.

Mr. JOYCE. I appreciate that and following up on his questions, too, it would seem to me from my visits that we have legacy systems that are putting band-aids on a system from the 1970s.

Would it make more sense to start a system that is 2017 and start working towards that one and eventually discard the legacy system? Wouldn't there be some cost benefit to that?

Mr. MCDONALD. One—that is a great point. One of the things that we are doing—and this is particularly through the health system—as you have heard from Alison's comments about the benefits, she and her team have done a great job bringing this, modernizing this, digitizing this, and getting this going.

Admittedly, we have more work to do yet, but we are on the way.

BLUEPRINT FOR EXCELLENCE

In the health care system, we have got some more fundamental work to do. Under Alison, under Carolyn's leadership, we put together something called the Blueprint for Excellence, which is a 10-strategy plan of returning the health care system to preeminence in the country. That plan talks about strategic partnerships. It talks about a hybrid system. That is the vision that we have.

As we continue to work, we will get more and more concrete on what that vision looks like. And I think that your point is exactly right. Rather than trying to take an operating room which needs to be 50 percent bigger, and trying to do that, maybe we go to an operating room in a university that we have an affiliation with. We have got great affiliations with the best medical schools in the country.

So, there is a lot that can be done. And we are going to be making that vision more and more concrete over time.

Mr. JOYCE. And I wish we would continue to discuss the ways we can help you get to where you need to go. Because it is important, and Madam Under Secretary, you brought up where you had a strong Irish voice—keep it up.

VETERANS COURTS

I know the frustration as a D.A. of 25 years, then you get to Washington, D.C. and it operates completely different and you

wonder where you are sometimes. But there are ways to streamline the process, and it seems, we're in trouble because of the antiquated system and that is just not acceptable. And the other thing—you had answered it in the last question too—as D.A.s, and I know with friends who are doing the same thing, I tell you it breaks your heart when you have to exercise prosecutorial discretion because veterans do something so they can get put in a place where they receive three squares and a roof over their head.

It is wrong and I know you have many programs to address that. But whatever we can do to make sure not one veteran is homeless, please be loud, be clear, and let us get that help to you.

Mr. MCDONALD. You are absolutely right. Incarceration for a veteran is a ticket to homelessness. And so, veterans courts—it was mentioned earlier in one of the members' testimony—veterans courts are a great way to deal with this. We are big advocates of veterans courts, we support veterans courts.

I spoke at the Harvard Business—Harvard Law School about veterans courts. And we want to do everything we can to put veterans courts in place in every state. Because if we keep veterans out of jail, we will keep them out of being homeless. It is a great point.

Mr. JOYCE. Thank you very much for your time here today.

I yield back.

Mr. DENT. Thank you for respecting the time on that.

That ends round one of the questioning; we will move into round two.

V.A. AND DOD INTEROPERABILITY

I want to try to conclude this hearing by lunchtime, by noon, again. So, Mr. Secretary, following up on Mr. Bishop's comments, and also Chairman Rogers about the interoperability to help work through the records.

Obviously you haven't been here for the frustrating experience of watching DOD and V.A. develop a single integrated health record then spend years and hundreds of millions of dollars on it, only to throw in the towel and go down two separate tracks.

DOD will soon award a contract for a new electronic health record. The V.A. is working to modernize its existing VistA health records. Both departments are sort of committed to making their records interoperable with the private riders that both active service members and veterans use.

I also want you to know that members of the House Appropriations Committee—we are strongly in favor of the integrated health record. And we are determined that the two records be interoperable. Just want to—again, hear your assurances that this is going to happen.

And, moreover, I want to talk a little bit about the money side of this. Congress provided $344 million for the V.A., electronic health record for fiscal year 2015. And despite all the increases elsewhere in the budget, you are requesting $111 million less than for 2016.

You indicate that less funding is required because the transition from moving from a single to two interoperable records took longer than anticipated leaving carryover 2015 funds. And that less 2016

funding better aligns with program requirements and workload capacity. The Committee certainly does not want to provide you with funding that you cannot use, but what does that say about your progress in modernizing VistA?

Will you still meet your deadline of reaching final operating capacity for VistA evolution by 2018?

Mr. MCDONALD. We are totally committed to maintain and making modern and useful our electronic health record. This has become even more important than it was before, because, as Steph alluded to earlier, we now have private sector doctors using our record.

I went to the American Medical Association Convention last summer in Dallas. And I talked a lot about how do I get every doctor in this country using our health record.

Our record is open source, which means it is free. Our record is crowd-sourced innovation, which means if a doctor uses our record and has an idea to improve it, we want that idea.

I think there is a real opportunity here to make our records the world class record it can be. And so it needs to go forward to the private sector doctor and then go backward in DOD. So the interoperability is actually essential in both directions.

Mr. WARREN. Sir, to your question about the reduction in the 2016 request:

It did take us longer when we moved from how we were doing a single record to how we are going to go forward, recognizing the sharing of information with third-party providers. So instead of asking for dollars in 2016 that we could not spend, we felt it was more appropriate to basically work off of the funds we carried over in 2014; the resources we received in 2015. And that is why there was a reduction in 2016.

We are still on track to make the interoperability commitments. In fact, that sharing of information, and again, Janus is just one piece of it—on track to meet that. And you will see a robust request for 2017 and 2018, as we pick back up the effort, again, work through the transition of reduction in 2016 because we could not spend those resources. And in 2017 you will see a robust request coming in.

Mr. DENT. Thank you.

SUICIDE AND MENTAL ILLNESS

Mr. Secretary, the recent Academy Award given to the documentary profiling the V.A. crisis hotline brought a fresh public spotlight on the tragic problem of suicide and mental illness and behavioral health among veterans that the V.A. has been battling for many years. In response to the problem over the years, the V.A. has increased its number of mental health practitioners, incorporated mental health services into primary care to reduce stigma, conducted research on effective treatments for service-related mental health issues and supported numerous outreach and prevention campaigns.

Can you tell us what additional steps the V.A. plans to take to battle suicide and serious mental illness within the veteran population? I know that you plan to hire more than 2,100 mental health

staff through the Choice Act funding by the end of 2016, as an example.

Mr. MCDONALD. The Clay Hunt Act was also helpful, and we are very thankful to members of Congress for the Clay Hunt Act. Because, as Carolyn said earlier, being able to repay student loans is an incentive to get more mental health professionals. And that allowed for a $30,000 repayment of student loans. It also allowed for more residencies, as I recall. And residencies becomes an issue.

Medical schools will tell you, they can produce more graduates. But without the residencies, it doesn't help. So, that is very helpful.

To me, the biggest thing we have got to do is outreach. We have got to find the veterans who are, for whatever reason, resistant to seeking that care. And I am very hopeful that with the "American Sniper," being such a successful movie and with our Academy Award that we won for our "dial 1" documentary, that this is going to create more visibility in the general public and help Americans realize that if they see someone—a veteran who may need help, to let somebody know about it.

We have a toll-free number that can be called, and we want to increase our outreach, both from veterans and from the general public and from family members, so that we can get in touch with these individuals, because we know if we get them into our system, that we can effectively treat them.

Dr. CLANCY. So one other point I would just make, Mr. Chairman, we take every suicide very, very seriously and almost personally, and in fact, we do what we call a behavioral health autopsy. That is to say, each case gets a very in-depth review, and the team has put together a database.

What they are doing now is trying to identify how we might use all of the data from our electronic health records and other sources to identify those at highest risk and target the outreach that the secretary just mentioned.

We think that there are going to be some early signals that we can be able to do that. It is a very, very difficult challenge but one that we are not letting up on.

CHOICE ACT

Mr. DENT. Very, very quickly—just quickly back to the Choice Act, Mr. Secretary, you are no doubt aware of the initial report on the Choice program the VFW organization released yesterday.

The group surveyed their membership to judge how many qualified and were able to use Choice, although the VFW report acknowledges that the V.A. didn't have much time to get the program running, that the V.A. has been working hard to improve it. The results of that they reported were disappointing.

VFW says that only 20 percent of veterans who live more than 40 miles from the nearest facility or who had to wait more than 30 days for an appointment were offered the Choice option.

Almost all those surveyed who were not offered Choice said they were interested in obtaining non-V.A. care.

Don't the VFW findings contradict your statements that not many veterans seem to be interested in using Choice to obtain non-V.A. care? My sense is many are very interested, just simply not eligible.

Mr. MCDONALD. No, as I said, we would like to do more with the Choice program, and we want to make sure every eligible veteran is able to take advantage of it.

I appreciate the VFW running that research. We sent out cards starting in November. The last cards went out in January. That research started in December, so—and was completed recently.

So it is going to take time, but we are redoubling our efforts, as I said earlier, to make sure every veteran knows of their qualifications for the Choice program and every veteran can take advantage of it.

We appreciate the VFW running the research.

Mr. DENT. Thank you.

At this time, I yield to Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman.

I want to turn to some parochial issues.

GAS TO ELECTRICITY CONVERSION

I have heard that some V.A. hospitals are looking at converting their energy supply to gas from electricity and understand that the Atlanta V.A. is studying a possible conversion.

Apparently, any type of conversion could cost a significant amount of money in capital cost. What is the thought process and analysis of this decision?

Mr. MCDONALD. I am not aware of that specific situation, Ranking Member Bishop, but I know from my private sector experience, I have converted different plants from natural gas to electricity and back and forth, or use co-generation. So I am assuming that the study would have to show a rate of return on that investment if we are going to make the capital investment.

I can assure you that, as the Secretary, I would not make that investment if there weren't an acceptable rate of return from the American people. But we will have to dig into that specific example.

Thank you.

Mr. BISHOP. Thank you.

MARTIN ARMY COMMUNITY HOSPITAL AND V.A. CLINIC

During our last conversation, you mentioned that there has been 18,000 square feet of space at Martin Army Community Hospital that would be allocated for a V.A. clinic. There was to be an initial allocation, as I understand it, of 10,000 square feet followed by 8,000 square feet a month later.

As you know, this is something that I have been asking for years, a co-location with DOD and V.A. clinics. Can you provide me an update as to the status of the transition?

Mr. MCDONALD. That is as much as I know is what you just said. We are in the process of making transition.

And again, I think this is a good example of another strategic partnership, and that is a partnership with DOD. And we appreciate your comments and the fact that you have been looking for this.

Caroline, I don't know if you have an update beyond that.

Dr. CLANCY. I understand that it is all on track, and there will be sort of a grand opening in May, but you better believe we will be letting you know about that.

Mr. BISHOP. Thank you. Thank you. Thank you.

V.A. CLINIC SELECTION, NORTH COLUMBUS, GEORGIA

Finally, we talked at length about the selection of a V.A. clinic in North Columbus, Georgia and the questions of the process utilizing the selection of the site.

Have you been able to find out anything in regard to the property selection there, and if it is truly the best location that will service the veterans in the Columbus, Georgia,—Alabama and surrounding areas?

Mr. MCDONALD. We did look into that. After we talked, we did look into that process. And frankly, I think that we could have done a better job involving your staff and you in that process of selecting that location.

The location is selected. We do think it is a good location, and if we were to change the location, my understanding is it would significantly delay us.

And as a result, we think it is best to move forward, but we do think that the process could have been improved of including your staff and you in the process of that.

Mr. BISHOP. It is my understanding that there is no public transportation that will go to that site and that there are very few veterans that actually live in that area, that the central city location would provide much greater access with public transportation and that there are facilities there that are already constructed as a part of the Columbus regional medical complex.

So I am trying to understand how they came to the conclusion that that was the best location.

Dr. CLANCY. I believe that transportation is going to be arranged for those veterans who would need transportation from—particularly if they are at that other complex and need to get out to our facility.

I believe that there was a problem with putting this facility downtown, but I will follow up with you on that.

Mr. BISHOP. Yes. Yes, I don't know what the problem was, other than that the specifications when they put the request for a proposal out excluded that particular geography where there was a tremendous medical complex in existence that had excess space.

It was already wired for all kinds of emergency transportation, for specialty services and the like.

Mr. DENT. I recognize Mr. Jolly.

Mr. JOLLY. Thank you, Mr. Chairman.

VACANT FACILITIES AND OBSTACLES

I just have one question I didn't get to last time. Mr. Secretary, you made a very reasonable argument and request regarding vacant facilities and one of the ways we could be helpful would be to remove the obstacles that stand in your way of closing facilities.

What are those obstacles on the congressional side? Are they merely political? Are they statutory? Are they tied to funding?

Mr. MCDONALD. I will have to get back to you on the details. My understanding is they are generally political, and—

Mr. JOLLY. I don't know who would stand by that one facility that you sent a picture of. I think you should able to close that one, right?

Mr. MCDONALD. Yes. That—that garage?

We obviously picked that picture on purpose.

Helen, do you have any—what do we need help on here? Is it statutory or—thank you for asking.

Ms. TIERNEY. Sir, it is a combination of different things.

We do have facilities such as that one that is designated as a historical facility, which, once that happens, we are not able to move forward.

And then it is a lot of political concern when we look to close a facility, so we need something like a BRAC process that would be fair, that a board would evaluate our facilities, and Congress would agree with those closures based on their ranking.

Mr. JOLLY. But do you have the authority to close vacant facilities? Let's stick with vacant facilities, not reducing the footprint of maybe existing facilities.

And I ask just because if it is political, then the category of vacant facilities, I think would be the low-hanging fruit with the least amount of political opposition.

Do you have the legal authority to close vacant facilities?

Ms. TIERNEY. So each case tends to be a little bit different. Sometimes that facility is on a complex, and we don't have enough construction money to tear it down.

An option when we start to do that process, one of the historical organizations gets involved—so yes, we would probably need an agreement that everybody was going to agree to close certain facilities.

Mr. JOLLY. Thank you.

Mr. DENT. Can we submit for the record what your authorities are? That would be very helpful.

[CLERK'S NOTE: The requested material was not provided by publication deadline.]

I recognize Mr. Fortenberry.

Mr. FORTENBERRY. This was related to the line of questioning I wanted to undertake.

But first of all, let me make a quick recommendation, if there is some viable mechanism whereby you can creatively dispose of excess inventory and capacity working with communities, do not call it BRAC. [Laughter.]

Don't do that, because this is a positive thing. We are trying to make you more efficient and effective, not close stuff in communities, and that means transitioning this vacant property, underutilized property.

By the way, the V.A. clinic in Lincoln, Nebraska, where I live, has a similar dilemma, a very old, stately facility that needs to be preserved—enhanced and preserved, and there is development agreements that have tried to be worked, and it is completely stuck.

And meanwhile, what is happening? The V.A. is carrying excess capacity, taking money away from your primary mission, the community is not being as well served, because there are other devel-

opment opportunities there, and we are losing the opportunity to rehabilitate and preserve historic structures.

So, I will think of—I will come up with an acronym if you want, but don't say BRAC.

Ms. TIERNEY. Sorry. We have a legislative request that we have submitted to give us enhanced use lease authority. Right now, our authority was limited to only supportive housing for homeless veterans. We would like to extend that back to the authority we used to have so we could bring in a broader range of people to use those beautiful historic facilities.

Mr. FORTENBERRY. Well, perhaps, Mr. Secretary, this is the heart of the problem that we have all been talking around with our lofty ideals and strategic partnerships. The mechanism for this—one of them, anyway, to create a financing mechanism—could be this enhanced leasing authority, where private bill would lease back, or however you want to structure it.

You said it—"We used to have the authority." You no longer do. What happened?

Mr. MCDONALD. I think part of it was around the issues in Los Angeles that I mentioned earlier. The Los Angeles campus had a rental car facility, a laundry facility, and a whole bunch of other things. And as a result of that, the enhanced use lease authority got restricted. I think we are beyond that now. We have solved the problem in Los Angeles. This would be helpful.

The other thing that would be helpful—and we have done a lot of study on this—is, with the strategic partnerships, we also have the ability to create mechanisms where we could receive funds from private sector to help veterans. And we have looked at that authority, as well.

Mr. FORTENBERRY. Well, I think what would be helpful—and you alluded to this earlier—is if we can quantify what you need in terms—across multiple platforms, what we have talked about, in terms of enhanced authority that is going to give us creative opportunity to have the private sector either contribute, or be involved in the financing. So, we could just get going here. There is no reason for all of this holdup. It is just that we are carrying legacy infrastructure of previous ideas as to how to do things. Not a condemnation of the past. We had to do it that way. But we don't have to do it that way going forward.

So, I think as an outcome here—tangible outcome—can you get back to us with the list after the evaluation is done, what specific legislative authorities you need? Or if it is a matter of just cross-agency communication, as we talked about with the OMB——

Mr. MCDONALD. Right.

Mr. FORTENBERRY [continuing]. Who has some stress regarding enhanced leases or private bill with private build leased-backed arrangements—that would be very helpful.

Mr. MCDONALD. We will do that.

Mr. FORTENBERRY. If you could do that quickly, that would be——

Mr. MCDONALD. We will do that. We will do it very soon.

Mr. FORTENBERRY. All right. Thank you, Mr. Secretary.

Mr. DENT. Thank you. That concludes the second round.

But before we depart, I want to ask one quick question and then will submit the balance of my questions for the record.

Mr. Secretary, your predecessor set goals of ending the disabilities claims backlog of defining backlog as taking longer than 125 days per claim. And achieving a 98 percent accuracy in completing claims by 2015.

Your budget document states that you will meet the timeliness standard—outside observers are a little more skeptical. It appears that trend in backlog reduction has declined in the last 8 months.

Your budget documents are silent about whether you will be able to meet the 98 percent accuracy goal by the end of the year. Why has that goal proved more elusive to you and what steps, like training, are necessary for you to achieve your quality goal?

Mr. MCDONALD. On that particular goal, we have done a deep dive on the statistics of that goal. And statistically, it is virtually impossible to achieve it. Statistically, if you have two probabilities—let's say one is .5 percent, the other is .5 percent—together, they are .25 percent. If you add another one, you know—and the probabability keeps going down the more elements you add.

We did a deep dive on this, and there are so many elements to achieving a perfect claim resolution that it would be impossible to get to 98 percent.

Allison, any detail you want to add?

Ms. HICKEY. The only thing else I would add is that I have met now repeatedly with commercial industry experts and chief claims officers from across the nation who do similar work. And when I describe to them the level of quality we have already attained, and then I say to them, "How would you get further?", they say to me, the return on investment would be so huge to get further that they actually believe—and when I asked them about their numbers, I am actually ahead of most of them in terms of the quality that they do. They didn't say just have a process on the back side for which—a working appeals process with good law around it—have a process on the back side for which you address those points of disagreement.

I think it is important to also note there is no correlation today between quality and appeal. We have done that study and that analysis. In fact, some of our best stations had the highest number of appeals.

So, what I would tell you is that we are really optimizing the system right now at that 96 percent medical issue quality. Which, by the way, is a 5.5 million issues we have done this year, and will go up again next year. So, we are actually doing pretty well against that at the individual medical issue level.

We have—and I thank you for the resources—significantly improved our training programs, our challenge programs. And we even have sort of remediation now—programs which you assisted us with. We also have consistency studies we are doing every day. We have quality review team people in the regional office who are providing just in time assessment of errors.

We have almost seven or eight layers of quality assurance now that I would actually say probably supersedes what even industry does in this area.

Mr. DENT. Thank you for that.

This concludes our hearing. I want to thank all of you today—the secretary and staff for appearing here.

And this hearing is adjourned.

[Questions for the Record submitted by Chairman Dent for the Honorable Robert A. McDonald follows:]

Question 1: More than one year ago, VA awarded two contracts to operate the new Patient-Centered Community Care Program (PC3), which VA describes as "a program that contracts with vendors to develop a network of health care providers to deliver covered care to Veterans when local VA Medical Centers cannot readily provide the needed care to Veterans due to demand exceeding capacity, geographic inaccessibility or other limiting factors." It is our understanding that the PC3 program was designed to ultimately replace VA's traditional "Fee Basis" program with a more uniform set of requirements and consistent rates paid at or below Medicare rates. Similarly, the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) also reimburses providers at or below Medicare rates.

a. To what extent does the VA plan to continue to rely on its traditional Fee Basis program and local contracts when providing care in the community instead of using the PC3 and Veteran's Choice Program?

VA Response: Non-VA Medical Care is hospital care and medical services provided to eligible Veterans outside the VA Health Care System when the required treatment or services are not feasibly available or geographically accessible at the nearest VA Health Care Facility. PC3 and Choice are integral parts of VA's strategy to provide access to care. When PC3 and Choice are not available, for example, because a Veteran does not meet applicable eligibility criteria or the needed service is not covered, agreements for non-VA medical care under other authorities may continue to be used. It is important to note that the Choice Program was established as a temporary program to improve Veterans' access to care.

b. What percentage nationally of VA's community care authorizations are still provided through Fee Basis and local contracts as compared to PC3 or the Choice Program?

VA Response: National utilization of PC3 since full implementation has been approximately 10% to 12%. The remaining 88% to 90% of care in the community is furnished under local agreements. The utilization analysis of PC3 excludes services that are not covered by PC3, such as Dental, Homemaker/Home Health Aide, Dialysis, and Compensation and Pension authorizations.

c. Are some facilities or VISNs higher users of the new programs as compared to others?

VA Response: Yes, there is a range in PC3 utilization. In February 2015, some facilities had utilization rates of PC3 over 50% (ranging from X% to Y%). VISNs had utilization rates at 10%

d. Why is the Fee Basis program still necessary and how much longer does VA anticipate needing that program?

VA Response: VA anticipates that it will continue to rely on agreements for non-VA medical care to provide hospital care and medical services that are not feasibly or geographically available within the VA Health Care System or any other VHA or Federal facility. When PC3 and Choice are not available, for example, because a Veteran does not meet applicable eligibility criteria or the needed service is not covered, agreements for non-VA medical care under other authorities may continue to be used.

e. What, on average, does the VA pay to health benefits managers under the PC3 and Choice models versus what it is commonly paying providers in the community when using Fee Basis or local contracts?

VA Response: The PC3 contractors are paid based on a negotiated Medicare percentage for any authorized care provided. Contract pricing can be below, at, or above the Centers for Medicare and Medicaid Services (CMS) rate, as a percentage. With some exceptions, under Choice, VA pays the difference between the amount covered by a Veteran's other health insurance, if any, and the applicable Medicare rate.
Reimbursement rates for non-VA medical care are governed by Federal regulation and are based on Medicare rates. In the absence of an applicable Medicare rate, VA reimburses providers via the VA Fee Schedule amount.

Question 2: Mr. Secretary, in your Senate hearing last week, you said that 500,000 veterans had made calls inquiring about appointments at non-VA facilities using their Choice cards, but that only 44,000 appointments had been scheduled. The implication was that veterans don't seem to be as interested in using the Choice program as anticipated. But how many of those 500,000 callers didn't schedule appointments because they were told they didn't meet the distance or time delay parameters to qualify for Choice?

VA Answer: There is insufficient data to fully answer this question. While weekly reports do contain line item Veteran call data, it is not detailed enough to discern the outcome of the call. For example, the data does not show if a Veteran called and requested care but was declined due to eligibility or merely called the third party administrator (TPA) with a question about eligibility. Moreover, we don't have line item call data prior to the beginning of February 2015. The TPAs have been instructed to inform ineligible Veterans to contact their nearest VAMC. We will continue to examine data collection needs related to the Choice Program.

Question 3: You indicated in the Senate authorizing committee hearing that you were hoping to get more information from the contractors that operate the Choice program and create a new algorithm for the 40-mile limit. But we thought the reason that the authorizers haven't already tried that is that the increased cost to the program would quickly deplete the $10 billion appropriated. How do you think you can get around that problem?

VA Response: Since implementing the Choice program, VA has found that the "straight-line" distance requirement to determine 40-mile eligibility has negatively impacted some Veterans. We believe that changing from a calculation of 40-mile "straight-line" distance to the actual driving distance is in the best interest of Veterans, and can be accomplished within the $10 billion appropriation. On March 24, 2015, VA published an interim final rule that changed the calculation used to determine the distance between a Veteran's residence and the nearest VA medical facility from a straight line distance to driving distance.

Question 4: You mentioned in your Senate hearing that non-VA fee or contract care provided to veterans has increased by 48 percent from a year ago. How do you explain this increased use of non-VA care? Are VA providers recognizing on their own that it makes sense to provide non-VA care in situations where veterans have to wait or go long distances for VA care?

VA Answer: The Department of Veterans Affairs (VA) has accelerated access to care for Veterans across the country, both in VA facilities and in their communities. Non-VA care authorizations have significantly increased since VHA implemented the Access to Care Initiative and the Veterans Access, Choice and Accountability Act of 2014. Increased reliance on non-VA providers may be attributed to expanded awareness of VA wait times and resulting initiatives that utilize Non-VA Medical Care programs as a remedy to Veteran access to care. Additionally, VA is focusing on educating Veterans and staff on the variety of authorities that allow Veterans to seek care outside of VA rather than waiting for a VA appointment or traveling to a VA facility, helping VA providers recognize when to implement non-VA care options.

Question 5: Your budget indicates that you will need to spend $1.2 billion in FY2017 for sec. 801 VACAA costs previously funded in that bill. What do you expect to spend in FY2018 for sec. 802 VACAA costs once that permanent, mandatory funding is exhausted?

VA Answer: The emergency resources provided in the Veterans Choice Act are being used to provide Veterans with additional access to health care within the community while the Department builds internal capacity.

Because VA has limited experience with the new Veterans Choice Program, it is difficult to predict Veterans' use of the program, or its interaction with the medical care base budget. Our original estimates of the total health care costs for the Choice Program ranged from a low of $3.8 billion to a high of $12.9 billion over the three-year program.

The budget impact of the Veterans Choice Program in 2018 will be addressed in the 2017 President's Budget, anticipated to be released in February 2016.

Question 6: What are the five year cost estimates (FY2016-2020) incorporated in the President's budget for discretionary VA funding that will be required to backstop activities formerly supported through VACAA?

VA Answer: FY 2018 estimates for activities formerly supported through VACAA will be provided in the FY 2017 President's Budget submission, anticipated to be released in February 2016. Estimates for years beyond FY 2018 will be provided in the applicable President's Budget submission.

Question 7: What is the dollar amount and percentage of total FY 2014 medical services funding that was provided for non-service-connected (as opposed to service-connected) care for veterans?

VA Answer: Many, but not all, of the medical care services provided to Veterans are tracked by service-connection. Pharmacy and non-VA care are two large cost items that do not distinguish the purpose of the service. In FY 2014, $37.19 billion of care was documented as being for non-service-connected conditions. Documented non-service-connected care was 64.3% of the total FY 2014 VA Medical Care budget.

Question 8: Identify the number of veterans receiving VA treatment for the following diseases, along with the associated funding for that treatment: cardiovascular disease; cancer (all types); diabetes; Parkinson's disease; Alzheimer disease; HIV; chronic obstructive pulmonary disease; hepatitis (all types); stroke; epilepsy; PTSD; traumatic brain injury; hearing loss; ALS; and arthritis.

VA Answer:

FY 2014 Veteran Counts, Expenditures, and Obligations by Disease Category			
Disease Category	Unique Veterans	Expenditures	Obligations
ALS	3,825	$65,643,371	$72,997,530
Alzheimers	20,533	$190,142,605	$215,041,409
Arthritis	1,018,735	$1,192,438,687	$1,275,304,897
COPD	390,113	$577,260,644	$644,081,697
Cancer	676,189	$2,528,752,937	$2,761,310,525
Cardiovascular Disease	2,022,768	$3,515,701,206	$3,893,618,921
Diabetes	1,078,677	$1,031,757,370	$1,136,521,180
Epilepsy	26,768	$61,850,808	$68,819,655
HIV	24,014	$54,417,521	$60,467,903
Hearing Loss	870,925	$340,490,298	$362,406,349
Hepatitis	74,309	$87,587,804	$95,549,141
PTSD	574,739	$1,148,591,466	$1,255,286,651
Parkinsons	35,595	$122,876,713	$135,138,595
Stroke	152,771	$676,038,390	$753,144,427
TBI	33,800	$87,736,665	$94,384,122
Total		$11,681,286,485	$12,824,073,002

Note: The costs and obligations are for the encounters where the primary diagnosis code was for the specific disease category; however, Veterans may receive treatment for more than one of the disease categories.

Question 9: What is the current complete claim (versus issue) accuracy rate for disability claims and what do you expect it will be by the end of fiscal year 2016?

VA Response: The Veterans Benefits Administration's (VBA) progress in eliminating the disability compensation claims backlog has not come at the expense of quality. Through VBA's Transformation Plan and a major investment of resources, claim-based accuracy increased from 83 percent in June 2011 to nearly 91 percent in March 2015. At the medical issue-level, accuracy has improved to 96 percent, from 93 percent when VBA began reporting in 2012.

VA's strategic goal of 98-percent accuracy was first reflected in the 2005 President's Budget Submission set at the direction of former Secretary Principi. The goal was not based upon any statistical analysis or modeling regarding the accuracy level that is reasonably achievable in VA's complex disability compensation program. Nor was it based upon an assessment of VBA's quality assurance program, which at that time used only the 12-month cumulative average of overall claim-level accuracy. In 2010, former Secretary Shinseki reaffirmed VA's commitment to providing Veterans timely, high-quality, decisions on their disability claims and set an aspirational goal that all claims would be processed at a 98-percent claim-based accuracy level in 2015. This aspirational goal was intended to drive VBA's claim processing accuracy as high as possible.

VBA contracted for an independent assessment to determine whether our aspirational 98-percent accuracy goal for claims processing is reasonably achievable and effective in driving further quality improvements. The contractor concluded that for VA to process 98 percent of all claims completely error free (with five medical issues per claim, on average), individual claims processors would have to have an error rate of 99.95 percent not considered to be achievable in a human-operated system such as VA's claims processing system. The contractor recommended that VA reassess its accuracy goal and set new goals that are based upon statistical analysis, process improvements, and historical performance. In their recently released Independent Budget for FY 2016, the Veterans Service Organizations (VSOs) acknowledged that VA has made significant progress toward reaching its 2015 aspirational goals, but also stated that now is an appropriate time for VA to reassess whether those goals are still appropriate and achievable or if new, more realistic goals need to be set. In order to ensure that Veterans and Survivors receive decisions of the highest possible quality. VBA formed a Quality Task Force comprised of both VA and external stakeholders, to include Veterans Service Organizations and industry experts, to to determine an achievable goal. Members include Veterans Service Organizations (VSOs), the Advisory Committee on Disability Compensation (ACDC), Calibre, and private sector executives. The first meeting was held in April 2015.

Your testimony included a chart that references the percent of veterans receiving disability compensation, and the dramatic increase from a 40-year average of 8.5 percent to 19 percent in 2015. We need to understand the underlying data and the

degree to which each of the underlying causes is affecting the total. The testimony references a variety of factors that contributed to this rise.

Question 10: For the record, would you indicate how much the various factors you mention contributed to the increase, and over what time period the data has been tracked? For example, to what extent does a change in survivability contribute and how has that changed over the time referenced? To what extent does the VSO assistance in applications contribute? Include all factors noted in the testimony, as well as others that contribute, over the time period noted in the chart (to the extent that data is available).

VA Answer: Listed below are some of the factors contributing to the increase in the percent of the Veteran population receiving disability compensation. While the individual impact of each factor cannot be measured, they have all contributed to fulfilling VA's mission to serve and honor the men and women who are America's Veterans.

Increased percent of Veterans applying for benefits: The percentage of Veterans from Iraq and Afghanistan applying for disability compensation is higher than previous periods of service. In 2012, VA reported 45 percent of Veterans from the wars in Iraq and Afghanistan were filing disability claims, compared to an estimated 21 percent from Operation Desert Storm and Desert Shield in the 1990s.

Agent Orange disabilities: VA has 14 presumptive conditions associated with Agent Orange exposure in Vietnam, including diabetes added in 2001 and ischemic heart disease added in 2010. As of March 2015, nearly 454,000 Veterans were receiving disability compensation for a combined 698,000 Agent Orange-related conditions, including, nearly 355,000 for diabetes and 200,000 for ischemic heart disease. Although the Vietnam Era ended in 1975, the number of Veterans from this era receiving compensation benefits has increased from 738,000 in 2000 to nearly 1.3 million in 2015, primarily due to the addition of these Agent Orange presumptive conditions.

Medical advances: Advances to better understand and diagnose disabilities, such as post-traumatic stress disorder, have played a role as well. Improved medical equipment and technology have enabled more Veterans to survive wartime injuries.

Longevity of recent conflicts: The conflicts in Iraq and Afghanistan have contributed to an increased number of Veterans filing disability claims. In 2000, approximately 300,000 Gulf War Era Veterans were receiving disability compensation. By the end of 2014, this figure increased to over 1.6 million Veterans.

Improved access to benefits: Through improved outreach efforts, mandatory participation in the Transition Assistance Program, and the joint VA-DoD pre-discharge programs, Veterans are better informed about their eligibility for disability benefits. In addition, improved access through eBenefits has made it easier than ever for Veterans to apply for benefits, including claims for increased disability ratings as conditions worsen or Veterans develop additional service-connected disabilities.

a) Describe management controls (other than the Appeals process) to make certain that veterans are properly vetted for SCD. To what degree are veterans who should be included, included, and to what degree are veterans who should not be included, excluded?

VA Answer: Every month, VBA selects a random and statistically valid sample of completed claims from every RO to review for quality. The sample of cases does not consider whether VBA denied or granted the claim. This Systematic Technical Accuracy Review (STAR) assesses the propriety of VBA's actions and the accuracy of its decisions.

When a quality deficiency is identified, a technical assistance team from VBA's STAR staff may provide additional training on identified error trends as well as training for local quality reviewers. Training is conducted using a variety of methods, including a monthly national Quality Call addressing national error trends identified in STAR assessments. VBA uses the error trends and accuracy findings to improve overall quality. In addition, challenged ROs will engage an identified high-performing mentoring RO to share best practices and identify opportunities for improvement.

In addition, Quality Review Teams (QRTs) work in every RO to review compensation and pension rating claims. These teams are tasked with evaluating RO and individual employee-level accuracy and performing non-punitive in-process reviews (IPRs) to eliminate errors at the earliest possible stage in the claims process. IPRs are conducted at strategic points in the claims process with immediate feedback provided to employees who take appropriate corrective action on identified deficiencies.

The local spot checks on random cases at ROs using the IPR, coupled with the national STAR assessments on random cases, help ensure VBA correctly decides claims for service connection and also properly evaluates the Veteran for compensation.

Question 11: How do you respond to the criticism that MyVA simply adds another layer of bureaucracy to the existing structure of local offices, networks and regional offices?

VA Answer: The new regional alignment will serve two purposes. First, the regions will align the disparate organizational boundaries of the Department into a single framework, easing internal coordination and collaboration between business lines. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA rather than individual organizations. Second, the regional framework will set the conditions for the rollout of the Veteran Experience office that will be responsible for providing customer service training and enhanced customer service capabilities across the Department. The regional framework also allows for experimentation and piloting of other functional support capabilities. This regional framework will not add an additional layer of bureaucracy over the existing operational business lines.

Question 12: Does policy control shift in the MyVA plan? Will the new regional directors have policy decision-making authority over the existing regional authorities?

VA Answer: Policy control shift does not change under the MyVA plan. There will be no changes to the job duties and responsibilities of the individual facilities. Medical Center

directors, Regional Office directors, and cemetery directors remain fully responsible for the operations of their facilities.

Question 13. If there is an interruption in funding for construction of the Denver VA hospital, will the theory of "sunk costs" kick in and the VA will look to other ways to provide care besides building a new hospital?

VA Answer: VA is committed to delivering timely and high quality health care to our Nation's Veterans. The new medical center facility in Aurora, Colorado, was funded over several fiscal years for a total of $800,000,000. VA has approved internal reprogramming requests totaling $99,895,000, and PL 114-25 authorized the transfer of an additional $150 million from other VA sources, making the total project cost to date $1.05 billion. These reprogrammings will have no effect on existing major construction projects.

These reprogrammings will enable the Department to continue project progress through the end of FY15 using an interim contract with Kiewit Turner, the original contractor on this project. To continue the project, VA submitted a report to Congress identifying two funding options that would fund the completion of the replacement hospital in Aurora. VA believes that continuing construction represents the best solution for Veterans in the Denver area.

Question 14. Mr. Secretary, there has been much conflicting information in press reports about exactly what actions the VA has taken to remove personnel responsible for the wait list problems at various VA facilities. I'd like to give you a chance to clarify the record on how many VA staff have been fired (versus reprimanded or allowed to retire or reassigned) specifically in connection with the wait list scandal. What is the precise number on that?

VA Answer: Last year, the VA Office of Inspector General (OIG) initiated investigations at 98 VA health care sites (hospitals and clinics) based on allegations of intentional manipulation of scheduling and/or wait list data at those sites. As of April 21, 2015, OIG has completed its work at roughly half of those sites, and has found no intentional manipulation of data at nearly two-thirds of the sites completed. At the other third, the OIG found some irregularity in scheduling or wait-list data entry, but in most cases was not able to substantiate intentional data manipulation.

As the OIG completes its reports, the Department's Office of Accountability Review reviews the reports and supporting evidence to determine whether accountability action can be taken based on OIG's evidence; whether an administrative investigation is necessary to complete the evidentiary record; or whether the matter should be closed out based on the OIG's finding that nothing improper had occurred.

As of April 21, 2015, the Department has taken action against eight employees who were determined to be culpable for scheduling improprieties at 4 sites, and is considering discipline for employees at a fifth site. The actions taken have ranged from admonishment to removal, depending on the individual employees' level of culpability and the extent to which the evidence clearly established intentional manipulation.

Question 15: Since July 2014, how many VA whistle-blower cases have reached the Office of Special Counsel? How many of those have been resolved; in particular, how may have been resolved in favor of the whistle-blower?

VA Answer: The Office of Special Counsel (OSC) is an independent agency, and not a component of VA.
VA does not have data specific to OSC whistleblower retaliation cases. However, according to data OSC provided to VA, OSC received 993 VA-related prohibited personnel action cases (of which whistleblower retaliation is a subset) in FY 2014. OSC predicts that it will receive 1,374 such cases in FY 2015. Thirty four VA-related prohibited personnel action cases were resolved in favor of the complainant in FY 2014, and OSC forecasts that 48 such cases will be resolved in favor of the complainant in FY 2015.

Question 16: Describe the organizational changes that have been implemented to more appropriately deal with VA whistle-blower charges and senior staff conduct allegations, such as the Office of Accountability Review.

VA Answer:

- Since June 2014, ninety one percent of our medical facilities have new leaders or leadership teams. This percentage is inclusive of both newly placed, permanent leaders and those acting in a detailed role.
- VA has established the Office of Accountability Review (OAR) to ensure leadership accountability for improprieties related to patient scheduling and access to care, whistleblower retaliation, and related matters that impact public trust in VA.
- Over 6,540 Network Director/Medical Center Director site inspections have been completed. (4,706 visits were completed in FY 2014)
- Over 8,309 staff have completed the VA-developed training "Access and Scheduling Core Concepts and Business Practices".
- VA leadership sent a message to all employees regarding the importance of whistleblower protection, emphasizing that managers and supervisors bear a special responsibility for enforcing whistleblower protection laws. All VA supervisors, including Senior executives are required to take annual "Whistleblower Rights and Protection & Prohibited Personnel Practices" training.
- VA has initiated establishment of a Department-wide program office to implement our Anti-Harassment Policy. This new program will ensure that allegations of harassment are promptly investigated and that VA management is alerted to conduct that is not consistent with our ICARE Values.
- VA's goal continues to be strengthening its culture of accountability and putting renewed focus on employee-led, Veteran-centric change. Improvements in workforce culture, with a focus on ICARE values, will allow VA to address issues as they arise, rather than necessitating employee termination following repeated and/or pervasive poor behavior.

The testimony included a chart titled "Average Degree of Disability" and noted that the degree of disability was nearly constant at 30 percent for 45 years, and has increased dramatically to 47.7 percent. As noted in the question above, it is important to understand the underlying data and the

degree to which each of the underlying causes is affecting the total. The testimony references a variety of factors that contributed to this rise.

Question 17: Mr. Secretary, we were pleased that you said in your Senate authorizing committee budget hearing that the budget request for the VA Office of Inspector General was an administrative error and that $15 million will be added to the 2016 IG request. How does the Administration plan to communicate this budget amendment to us and when we will receive it?

VA Response: To provide these resources in a responsible, deficit-neutral way, the Department has requested that Congress enable VA to use $15 million from Section 801 of the Veterans Choice Act to increase funding for the Office of Inspector General (OIG). This request was included in Deputy Secretary Gibson's April 21, 2015 letter and funding plan to Congress requesting $830 million from section 801(a) of the Choice Act to fund the completion of the Denver Replacement Medical Center and $15 million for OIG to provide increased oversight of VA operations.

Question 18: The Centers for Medicare and Medicaid Services recently authorized a new DNA stool-based colorectal cancer screening test as eligible for Medicare coverage. Under current policies, it takes one year for the Department of Veterans Affairs to process any new medical item for inclusion in the Federal Supply Schedule. In the interest of improving the accuracy of colorectal cancer screenings, has the Department given any consideration to expediting that one-year time-frame in order to make new, innovative solutions for colorectal cancer screening available to our veterans in as timely a manner as possible?

VA Answer: There is an active procurement action ongoing through the Federal Supply Schedule (FSS) multiple award schedule program, which means more than one company is awarded a contract for same or similar products and/or services. While this action occurs, this DNA stool-based colorectal cancer screening test may be obtained by the medical centers as necessary, in compliance with prescribed acquisition regulations and policies.

Question 19: For the record, would you indicate how much the various factors noted in your testimony have contributed to the increase, and what the trend is over the time period noted in the chart?

VA Answer: Listed below are some of the factors contributing to the increase in the average degree of disability for Veterans compensation. While the individual impact of each factor cannot be measured, they have all contributed to fulfilling VA's mission by ensuring Veterans are fairly compensated for disabilities resulting from their service.

Increased number of disabilities per Veteran: Most of the growth can be attributed to the increasing number of disabilities per Veteran, particularly from the Gulf War Era. As Veterans have more service-connected disabilities, their combined disability evaluation increases. As noted in testimony, the current number of service-connected disabilities per Veteran by period of service is as follows:

- World War II: 2.5,
- Korean Conflict: 2.9,

- Vietnam Era: 3.8, and
- Gulf War Era: 5.9.
    - Global War on Terror (GWOT): 7.1
    - GWOT Integrated Disability Evaluation: 10.5
    - GWOT Benefits Delivery at Discharge: 11.6

Agent Orange disabilities: VA has 14 presumptive conditions associated with Agent Orange exposure in Vietnam, including diabetes added in 2001 and ischemic heart disease added in 2010. The average combined degree of disability for Veterans with an Agent Orange presumptive condition is nearly 68 percent, well above the overall average rating of 48 percent.

Medical advances: Advances to better understand and diagnose disabilities, such as post-traumatic stress disorder, have played a role as well. Improved medical equipment and technology have enabled more Veterans to survive wartime periods. However, these Veterans often return home with multiple and more severe disabilities.

Longevity of recent conflicts: The conflicts in Iraq and Afghanistan have contributed not only to an increased number of Veterans filing disability claims, but also to increased number of disabilities per Veteran.

Improved access to benefits: All transitioning Servicemembers are now required to attend the Transition Goals, Plans, Success (GPS) program, which is designed to help transitioning Servicemembers adjust to life after the military. Through GPS and other outreach efforts, Veterans are better informed about their eligibility for disability benefits. In addition, improved access through eBenefits has made it easier than ever for Veterans to apply for benefits, including claims for increased disability ratings as conditions worsen or Veterans develop additional service-connected disabilities.

a) What management controls does the Department have to make sure that the degree of disability is correct - that the veteran is has been evaluated properly to determine degree of disability and is receiving the proper level of compensation for his or her disability? Apart from the appeals process, does VA have other quality control mechanisms? Specifically report any activities or controls to make sure that you do not have "false positives" and the degree of disability is not over-stated.

VA Answer: The IPR and STAR quality reviews discussed in response to question 10b evaluate the correctness of decisions regarding evaluation of disability, as well as service connection. In addition, VA has mandated the use of standalone evaluation builder programs. Evaluation builders assist decision makers in assigning correct evaluations, generating the text explaining a disability grant, and providing the criteria for the next higher evaluation. These rules-based tools make rating decisions more accurate and consistent.

[Questions for the Record submitted by Chairman Rogers for the Honorable Robert A. McDonald follows:]

Question 1: It is my understanding that insomnia is one of the most common health issues facing veterans today. Insomnia is predictor of the onset of PTSD and can even lead to suicide attempts. Many of our veterans are taking multiple prescription drugs for both physical and mental ailments and it is well known that insomnia medications have serious side effects. Furthermore, the efficacy of insomnia medications decreases with use, and when a patient stops using these medications, their symptoms usually return. Cognitive behavioral therapy (CBT) is a highly effective treatment for sleep-related issues and is widely regarded by experts as the gold standard for insomnia treatment. For over 4 years now, this therapy has been accessible to patients over the Internet. CBT offered over the web is proven to work just as well as in-person therapy. Given all of these facts, can you please explain the VA's plans to offer internet-delivered CBT as a treatment option for veterans suffering from insomnia?

VA Response: Insomnia is indeed one of the most common health issues facing veterans today. Cognitive behavioral therapy for insomnia (CBT-I) is an empirically supported, non-pharmacologic treatment and is considered to be a first line treatment for insomnia by the National Institute of Health. CBT-I is equally effective in the short term and more effective in the long term than standard medications for insomnia (Jacobs, Pace-Schott, Stickgold, & Otto, 2004). The VA has been training mental health providers in Cognitive Behavioral Therapy for Insomnia using competency-based methods since 2010. In that time, over 640 VA mental health providers have been trained to provide this treatment. Research has demonstrated (Karlin, Trockel, Taylor, Gimeno, & Manber, 2013), that Veterans had significant improvements in insomnia, comorbid depression, and physical and psychological quality of life when treated by VA clinicians. Internet-delivered treatments can be an important part of a comprehensive continuum of care and are generally appropriate for some, but not all, patients with a target condition. There are several internet-delivered versions of CBT-I, that have demonstrated evidence of effectiveness for non-Veteran patients. To date, there has only been one promising unpublished study with Veterans using an internet-delivered CBT-I. VA has plans to develop an internet-based CBT-I course designed specifically for Veterans, with a contract award planned for the end of this fiscal year. This course will be based on CBT-I as disseminated and shown to be effective with Veterans. Veterans will be involved in the development and review process for the course.

Jacobs G. D., Pace-Schott, E. F., Stickgold, R., Otto, M. W. Cognitive Behavior Therapy and Pharmacotherapy for Insomnia: A Randomized Controlled Trial and Direct Comparison. (2004). Arch Intern Med., 164(17):1888-1896. doi:10.1001/archinte.164.17.1888.

Karlin, B. E., Trockel, M., Taylor, C. B., Gimeno, J., & Manber, R. (2013). National Dissemination of Cognitive Behavioral Therapy for Insomnia in Veterans: Therapist- and Patient-Level Outcomes. Journal of Consulting and Clinical Psychology, 81(5), 912-917. http://dx.doi.org/10.1037/a0032554

[Questions for the Record submitted by Congressman Bishop for the Honorable Robert A. McDonald follows:]

Question 1: What is the VA's plan to hit its target of eliminating claims backlog by the end of calendar year 2015?

VA Answer: VBA greatly appreciates the investments provided by the President and Congress over the past six years, and we are on track to meet the President's goal to eliminate the disability claims backlog and process all claims within 125 days by the end of 2015. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes to improve benefits delivery. Several integrated transformation initiatives, as described below, are focused on increasing the number of claims and issues completed per FTE. VBA anticipates eliminating the claims backlog through continuous implementation of the transformation initiatives carried out over the last several years as well as those highlighted below. The President's 2016 Budget will allow VBA to continue building on the success of these initiatives:

Veterans Claims Intake Program (VCIP): VCIP streamlines processes for receiving digital records and data into the Veterans Benefits Management System (VBMS) and other VBA systems, transitioning VBA from a paper-based claims environment to a digital operating environment. It scans paper claims, converts them into digital format, and extracts important data for input into electronic folders. VCIP has converted and uploaded more than 1.3 billion images from paper. In addition to supporting scanning operations for incoming claims, VBA's 2016 request of $140.8 million will allow the digital intake of military, income, and employment records from other federal agencies and private providers. This will broaden electronic evidence exchange for processing all types of claims more accurately and more rapidly by building additional interfaces for Official Military Personnel Folders (OMPF) from DoD and interfaces with health networks, hospitals, and private clinicians.

Centralized Mail: Centralized mail consolidates inbound paper mail from VA's ROs to a centralized intake site. This initiative expands VBA's capabilities for scanning and conversion of claims evidence, increases electronic processing capabilities, and assists in converting 100 percent of received source materials to electronic format. VBA has deployed centralized inbound mail for all ROs. The 2016 budget request of $18.3 million provides resources to sustain operations at all 56 ROs and positions VBA to expand centralized mail operations to other lines of business and centralize outbound correspondence to Veterans.

Veterans Benefits Management System: VBMS, as VBA's key business transformation initiative, provides a paperless claims-processing environment and improved business processes to support timely, high-quality decisions for Veterans and their dependents. National deployment of VBMS was completed June 2013 and provides access to over 28,000 end users. VBMS allows VBA to centrally manage the claims workload at the national level and direct cases electronically across its network of ROs to more efficiently match claims demand with available processing capacity. VBA went from touching 5,000 tons of paper annually to

now processing 95 percent of the claims inventory electronically in VBMS. As of March 18, VBA completed 1.38 million claims in VBMS. In 2015, VBMS is focused on delivering the National Work Queue (NWQ) and reducing reliance on legacy systems. In 2016, VBMS enhancements will focus on the Integrated Disability Evaluation System, appeals, and pension.

Veterans Relationship Management: The VRM initiative continues to facilitate an increasingly more Veteran-centric digital operating environment. VRM is delivering a scalable, enterprise-wide, services-based technology environment that will be the foundation for how Veterans are served and how benefits and services are delivered. This new model will provide VA an integrated services delivery platform with the approach of placing the Veteran at the center of the service with all business requirements and design being driven from the Veteran perspective.

Components of VRM include eBenefits, the Stakeholder Enterprise Portal (SEP), Customer Relationship Management solutions, Digits-to-Digits, Knowledge Management, and Veterans Online Application Direct Connect. Through the eBenefits portal, Veterans can submit claims for benefits, administer their accounts, and receive status updates. The eBenefits Web portal standardizes claim intake and enables collaboration with VSOs to assist Veterans with all interactions with VA. VA continues to expand the capabilities available through the eBenefits portal as more Veterans use the site. Today eBenefits has 4.4 million registered users and over 48 million visits annually. VBA's 2016 request for $13.8 million, in addition to the $67 million requested for VRM in the Office of Information Technology, will support ongoing operations and continued efforts to pilot and deploy new solutions for VBA mobile applications that expand access to self-service tools and benefits/services information in VBA portal environments; develop new service features in SEP for medical providers, loan officers, fiduciaries, and funeral directors; and integrate VetSuccess with Career Center for Veterans, enabling searches for jobs posted by unique employers targeting Veterans.

The FY 2016 budget request includes $140.8 million for the Veterans Claims Intake Program (VCIP), which is a continuation of a scanning program that began scanning on September 10, 2012

Question 2: How many scanning contracts does the VA have for VCIP?

VA Answer: VBA currently has one scanning contract for converting paper disability claims materials to electronic images to upload to the Veterans Benefits Management System (VBMS) for electronic claims processing. Under this contract, there are two vendors, each operating two scanning sites:

1. CACI International's sites are located in Newnan, Georgia, and Mt. Vernon, Kentucky;
2. Systems Made Simple (SMS) Incorporated's sites are located in Janesville, Wisconsin, and Clinton, Iowa.

By FY 2016, VBA will re-compete the scanning contract and award one new scanning services contract to two or more vendors.

a) How many documents are scanned per month?

VA Answer: Document-level information is unavailable, as the VBA scanning contract is based on the number of images uploaded to VBMS. For both vendors combined, the contract ranges between 40-77 million scanned images per month.

b) What happens to the documents after they scanned?

VA Response: After scanning, the files are separated into DoD and VA components. The components are boxed, labeled, and stored at the vendors' secure facilities. Final disposition is pending resolution of the return of service medical records to DoD.

c) Once a document is scanned how long does it take to get to completed package to a claims processor?

VA Answer: Scanning takes an average of five business days from receipt at the vendor's facility through upload to VBMS.

d) What percentage of disability claims are digital?

VA Answer: Through February 2015, 9.1 percent of claims have been filed digitally through eBenefits, and the remaining 90.9 percent of claims were submitted on paper. The Veterans Claims Intake Program enables conversion of paper claims to digital images for electronic processing in VBMS. As of March 18, 2015, 5.3 percent of rating claims pending were in paper format. This is down from 6.2 percent as of December 31, 2014.

Question 3: With the Army drawing down its end strength, is the VA prepared for an uptick in claims due to these separations? What steps are being taken to ensure the progress on reducing the backlog is not lost?

VA Answer: VBA is fully prepared for the forecasted uptick in claims received, and the above response to question 1 describes the specific steps VBA is taking to ensure backlog reduction continues.

Question 4: How many claims have been processed using the VBMS? What is the current percentage of claims that are filed on paper?

VA Answer: From December 20, 2011 through March 18, 2015, 1.38 million rating claims were completed in VBMS.

Through February 2015, 9.1 percent of claims have been filed digitally through eBenefits, and the remaining 90.9 percent of claims were submitted on paper. The Veterans Claims Intake Program enables conversion of paper claims to digital images for electronic processing in VBMS. As of March 18, 2015, 5.3 percent of rating claims pending were in paper format. This is down from 6.2 percent as of December 31, 2014

We are required by law to notify Veterans within 60 days of the incident occurring, and VA Handbook 6500.2 (see attached) requires VA to make notification within 30 days. We currently average 28 days to make notification.

Question 5: The average number of claimed conditions for recently separated Service members is now in the 12 to 16 range, which is an increase in the number of disabilities claimed by Veterans of earlier eras. Do claims processors have to have all claimed conditions verified before a claim can be processed or as conditions are verified the claim for that condition is approved?

VA Answer: VBA currently has authority to issue decisions on individual disabilities within the same claim. VBA has used this practice and further believes technological improvements underway will allow VBA to increase the use of this practice. VBA has established a policy, reflected in the Adjudication Procedures Manual, providing that intermediate rating decisions may be made when the record contains sufficient evidence to grant any claim at issue, even when other claimed issues require development for additional evidence.

Question 6: What steps are being taken to make sure that whatever system the DOD chooses VistA will be able to share information with it?

VA Answer: There are eight (8) steps we are taking to ensure that VistA will be an interoperable Electronic Health Record system, which means it will be able to share medical data with DOD and others. The 8 steps are the following:

1. Ensure Data terminology standardization
2. Ensure Clinical data standards harmonization
3. Ensure Data domain management
4. Utilize Consolidated-Clinical Document Architecture (C-CDA)
5. Standardize exchange methods through a health info governance strategy
6. Utilize enterprise shared service through a service-oriented architecture (SOA) infrastructure
7. Comply with the security continuous monitoring and information security risk management programs
8. Comply with the Health Architecture Review Board's (HARB) interoperability alignment framework

a) The VA and DoD were directed to develop an electronic health record system why has this been so difficult to achieve?

VA Answer: VA is committed to evolving its world-class electronic health record system, known as VistA. The Department of Defense is in the process of replacing its electronic health record system. Each Department is using the system that best meets its operational needs. Since interoperability does not hinge on a single system being shared, VA and DoD can use different systems as long as standardized data is shared. An analogy is the use of an Automated Teller Machine (ATM) card. You can use an ATM card from your bank to make transactions using ATMs owned and operated by different banks, and even ATMs in different countries. When you withdraw cash from another bank's ATM, it still updates your bank account information. These ATMs could be made of different hardware and running different software. But they share an understanding of standardized data—like PIN codes and dollar amounts— such that they are interoperable.

Health information is more varied and complex than bank account information, but the principle behind VA/DoD interoperability is much the same. VA and DoD have agreed on a set of standardized data, and the two Departments continually innovate ways to share that data so that clinicians on both sides can easily access it, improving Servicemember and Veteran health care and customer service.

b) Is the modernization of VistA going to be complete by the time DoD picks its system?

VA Answer: Yes, VistA will meet the required interoperability requirements by December 31, 2016, and VistA 4 will be complete by September 30, 2018.

The Department of Defense (DoD) is planning to select its vendor in 2015, but will not have its EHR system fully deployed until Fiscal Year (FY) 2022 Quarter four, based on DoD's notional schedule. DoD's Segment One, Initial Operating Capability (IOC), is notionally scheduled for FY 2017 Quarter two. The replacement of the DoD system represents a huge undertaking. DoD's system supports over 100,000 clinicians at 56 hospitals and 365 clinics, with approximately 9.8 million active-duty personnel and dependents enrolled.

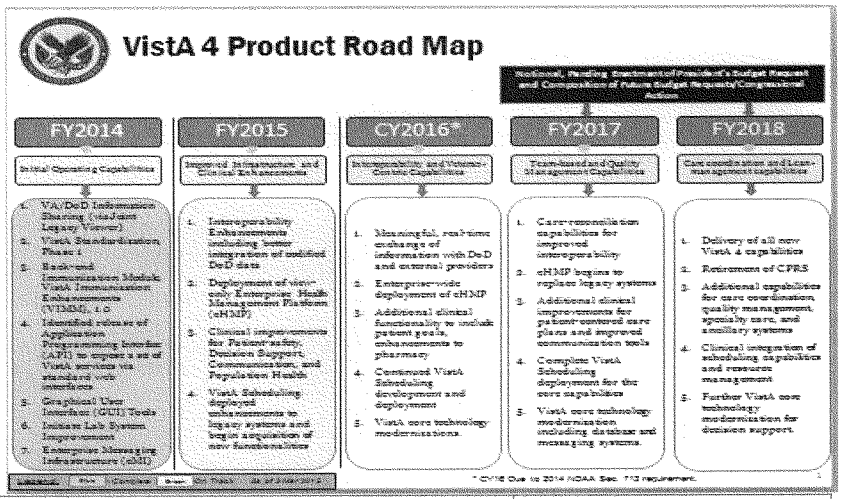
Achieving interoperability between these systems is very complex. On the VA side, there will be a need to monitor the large number of messages exchanged via the existing interoperability framework (i.e., the Bi-directional Health Information Exchange, or BHIE) and ensure their successful transition to the new Joint Legacy Viewer and electronic Health Management Platform, and decommission the BHIE.

c) With EHR being a priority, why is the FY 2016 budget for interoperability only $15 million.

Over the past five years, VA has placed a high priority on developing a wide base of systems in support of seamless interoperability. As FY16 marks the first full year of divestiture from the iEHR program, VA's focus throughout FY16 will be establishing the

internal organizational, programmatic, and technical infrastructure needed to support the VistA Evolution (VE) and Interoperability effort. This critical priority requires appropriate government and contract support, and VA emphasized both hiring and acquisitions in FY15. A new VE support contract is scheduled for award this year. The availability of these resources provides the basis for FY16's emphasis on infrastructure development. Additionally, VA has made significant strides toward defining clear, actionable requirements for upcoming development work. This requirements definition and validation will continue throughout FY16, again facilitating rapid development ramp-up in FY17 and FY18. The attached chart and the VE Road Map illustrate the technical progress planned for FY16-18. (Please send attachment with this response)

Attachments



Name	Description
VA HANDBOOK 6500.2.pdf	

Question 7: What is the plan for the additional $1.3 billion for medical care in 2015?

VA Answer: The total net increase of $1.299 billion is comprised of the following:

- The ongoing health care services estimate increased by $599.9 million compared to the 2016 estimate in the 2015 Budget, driven largely by estimates of the cost of new Hepatitis C treatments and updated actuarial trends based on the latest available data.

- A reduction in projected base appropriations health care costs due to enactment of the Veterans Choice Act; VA estimates that $452 million in requirements will shift from the regular program as Veterans who would otherwise receive care in the VA health care system instead choose to participate in the new Veterans Choice Program, as established in the Veterans Choice Act and funded by section 802 of the Act.

- The Long-Term Services and Supports estimate has increased by $51.1 million, reflecting trends in the most recent available data and continued investment into non-institutional settings.

- Ongoing health service programs not projected by the Enrollee Health Care Projection Model increased by $221.6 million. The Caregivers program cost estimate increased by $249.4 million, driven largely by an increase in the projected number of Caregivers receiving stipend payments. The combined sum of the estimates for CHAMPVA, reimbursement to the Indian Health Service and tribal health programs, caring for eligible Camp Lejeune Veterans and families, and readjustment counseling decreased by $27.8 million based on updated actuals and revised assumptions in workload for Camp Lejeune and Indian Health Service.

- VA programs to end Veterans' homelessness increased by $128 million, for a total of $1.393 billion. The increased estimate allows VA to fully support projected utilization in its homeless programs, including the Supportive Services for Veterans Families (SSVF) program and the Department of Housing and Urban Development-VA Supportive Housing program (HUD-VASH).

- Healthcare Infrastructure Enhancements increased by $666.9 million. Facility activation costs have increased by $468.2 million over the initial advance appropriation estimate of $130 million, to $598.2 million. The cost estimate of supporting the Veterans Integrated System Technology Architecture (VISTA) evolution project has been revised downward from $208.3 million to $159.6 million. Estimated non-recurring maintenance obligations grew from $460.6 million to $708.0 million, to address high-priority emerging capital needs identified through the Strategic Capital Investment Planning (SCIP) process; this increase excludes funding provided by the Veterans Choice Act. See Volume 4, Chapter 7 for additional information on the SCIP process and the NRM program.

- The cost of VHA-proposed legislation remains nearly unchanged, with an estimated cost decrease of $0.5 million. The 2016 budget includes estimates to extend eligibility for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) healthcare benefits for beneficiaries up to age 26.

- Additional budgetary resources decreased by $84.4 million (collections, reimbursements and transfers). The estimate for the Medical Care Collections Fund decreased by $26.3 million. Reimbursements decreased by $51.0 million and transfers to the Joint DoD-VA Medical Facility Demonstration Fund increased by $7.1 million.

Attachments:

Update to the 2016 Advance Appropriations Request
Excludes Veterans Choice Act
(dollars in Thousands)

Description	2016 Advance Approp.	2016 Current Estimate	Increase/ Decrease
Health Care Services	$49,882,074	$50,481,994	$599,920
Veterans Choice Program Cost-Shift		($452,000)	($452,000)
Long-Term Services and Supports:			
Institutional	$5,572,601	$5,526,958	($45,643)
Non-Institutional	$1,836,847	$1,933,555	$96,708
Long-Term Services and Supports [Total]	$7,409,448	$7,460,513	$51,065
Other Health Care Programs:			
CHAMPVA, Spina Bifida, FMP & CWVV	$1,854,870	$1,883,882	$29,012
Caregivers (Title 1)	$305,716	$555,096	$249,380
Indian Health Services (P.L. 111-148)	$38,649	$28,062	($10,587)
Camp Lejeune - Veterans and Family (P.L. 112-154)	$71,906	$19,720	($52,186)
Readjustment Counseling	$237,544	$243,483	$5,939
Other Health Care Programs [Subtotal]	$2,508,685	$2,730,243	$221,558
Ending Veterans Homelessness	$1,265,000	$1,393,000	$128,000
Healthcare Infrastructure Enhancements:			
VISTA Evolution	$208,265	$159,596	($48,669)
Non-Recurring Maintenance	$460,600	$708,000	$247,400
Activations	$130,000	$598,174	$468,174
Healthcare Infrastructure Enhancements [Subtotal]	$798,865	$1,465,770	$666,905
VA Legislative Proposals	$49,914	$49,375	($539)
Obligations [Total]	$61,913,986	$63,128,895	$1,214,909
Funding Availability:			
Appropriation	$58,662,202	$58,662,202	$0
Trns to North Chicago Demo. Fund	($252,073)	($259,145)	($7,072)
Trns to DoD-VA Health Care Sharing Incentive Fund	($15,000)	($15,000)	$0
Medical Care Collections Fund	$3,252,857	$3,226,548	($26,309)
Reimbursements	$266,000	$215,000	($51,000)
Funding Availability [Total]	$61,913,986	$61,829,605	($84,381)
Annual Appropriation Adjustment		$1,299,290	$1,299,290

Question 8: The goal of the MyVA initiative is to re-design the VA around the needs of Veterans and breaks the country up in to five regions. What is unclear to me is how this structure will work with the Regional Office structure. My concern is that this could be an additional layer for the Veteran to go through to get answers. Can you explain how this massive reorganization will be helpful to our Veterans?

VA Response: As with many other MyVA initiatives, the intent of moving to five districts is to allow for more effective and efficient internal VA operations that will result in better service to Veterans.

[1] The goal is better coordination and an improved Veteran experience. The new district alignment will serve two purposes. First, the districts are based upon state boundaries and will align the disparate organizational boundaries of the Department into a single framework, easing internal coordination and collaboration between business lines, and measuring results. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA rather than individual organizations. The end goal is that our internal operating boundaries will be transparent and irrelevant to Veterans. Basing the framework upon state boundaries will also enhance collaboration with external stakeholders. Second, the district framework will set the conditions for the rollout of the Veteran Experience office that will be responsible for providing customer service training and enhanced customer service capabilities across the Department. The district framework also allows for experimentation and piloting of other functional support capabilities.

It should be made clear, however, that the three Administrations (VHA, VBA, and NCA) will remain responsible for the delivery of their respective services and benefits and the district construct does not change those responsibilities or the reporting chains within each Administration. The three Administrations have been tasked to align their operations within the five-district construct. NCA is aligning its current five Memorial Support Networks into the realigned district framework. VBA is realigning from a four Area Office framework into the five districts. Finally, VHA is currently examining how to realign their VISN structure within the state-based boundaries of the district framework.

[2] The mission of the Veteran Experience (VE) Office is to support those Administrations in the delivery of excellent care and benefit experiences. Specifically, the VE Office will provide services that will enhance both healthcare and benefit delivery to include: 1) analysis and design of better customer interactions, and clearer Veteran satisfaction metrics based on developing consistent, shared knowledge of customer needs and requirements; 2) establishing streamlined business processes to build a seamless customer experience, to include establishing a unified digital experience (UDE) and an enterprise approach to VA's multiple national call centers that will enhance access to, and satisfaction with, VA healthcare and benefit delivery; 3) developing and delivering customer service training curricula and methodologies for front-line staff; 4) assessing and monitoring customer service performance, with feedback provided to health care and benefit deliverers; and 5) implementing better methods of assisting Veterans in navigating through the range of services and offices

within VA. The District VE offices will have relatively small footprints, approximately 24 people in each district, to support these functions at the local levels, with emphasis on customer service training, Veteran experience performance monitoring, and problem resolution. The District Veteran Experience Officers will report to the VA Chief Veteran Experience Officer (CVEO), who reports directly to the Secretary of Veterans Affairs. The relationship between the District VEOs and the local directors is intended to be collaborative and supportive, while not creating another layer of bureaucracy. However, the responsibilities of the District VEOs will include performance monitoring, problem resolution, and reporting of systemic issues related to the Veteran experience to the CVEO.

[1] VA had decided to name the five operational areas "districts" rather than "regions" to avoid confusion with the current VBA Regional Offices (ROs).

[2] Although the analysis is not yet complete, it is likely that each district will include multiple VISNs.

The MyVA reorganization will not change the current Regional Office structure within the Veterans Benefits Administration. The new regional alignment will serve two purposes. First, the regions will align the disparate organizational boundaries of the Department into a single framework, easing internal coordination and collaboration between business lines. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA rather than individual organizations. Second, the regional framework will set the conditions for the rollout of the Veteran Experience office that will be responsible for providing customer service training and enhanced customer service capabilities across the Department. The regional framework also allows for experimentation and piloting of other functional support capabilities.

VA is taking the first steps to realign the many organizational maps to create a more cohesive Department. These regions will serve two purposes:
First, the regional alignment will help Veterans to see one VA, rather than its many components. The regions will align the disparate organizational boundaries into a single framework, allowing for better internal coordination.

Second, this regional framework will allow VA to establish the new regional Veteran Experience offices, to provide customer service training and enhanced Veteran-focused capabilities across the Department.

VA's new regional design was the result of careful analysis of multiple proposals. The final regional map utilizes state boundaries, and each organization within VA will ensure their structure fits within this framework.

Question 9: The Veterans Choice Act provided $15 billion in mandatory funding to increase veterans' access to health care by hiring more physicians and staff and improving the VA's physical infrastructure and to establish a temporary program (the

Veterans Choice Program) improving veterans' access to health care. Now, I have heard from VSOs that implementation is not going so well.

a. Can you explain how you think the roll-out is going?

VA Response: VA's goal is to provide Veterans with timely and high-quality care with the utmost dignity, respect and excellence. VA is aware that users of the Choice Program have identified aspects of the law that are presenting challenges, resulting in confusion for Veterans or the Program not working for Veterans as well as it needs to. VA also recognizes that early utilization of the Choice Program has not been as robust as expected. VA continues to eagerly seek feedback on the program from all of our stakeholders, including Veterans, Veterans Service Organizations, our employees, and Congress. For example, after considering public comments on our regulations implementing the Veterans Choice Program, we changed the way we measure distance for purposes of determining eligibility for Choice. We now use driving distance rather than a straight-line measure. VA looks forward to turning other challenges into opportunities to improve our care and services. For example, section 101(b)(2)(D)(ii) of VACAA limits the considerations VA can take into account when determining if a Veteran living 40 miles or less from a facility is eligible for the Choice Program. VA may only consider whether the Veteran must travel by air, boat, or ferry to reach a VA medical facility or faces an "unusual or excessive burden...due to geographical challenges" when determining eligibility for non-VA care under this criterion. The Department asked in September 2014 to remove the "geographical challenges" language from VACAA in order to provide the Secretary with greater flexibility in providing health care for Veterans who face unusual or excessive burdens in reaching VA medical facilities. While the Department is educating staff and Veterans about this provision, this formulation does require VA to adjudicate claims that are very context-specific in nature. We believe legislation providing greater flexibility on this issue would enable more Veterans to receive care closer to home.

b. Can you help me understand why the program is underutilized and why the VA believes it needs flexibility with this funding?

VA Response: As previously stated, VA's goal is to provide Veterans with timely and high-quality care with the utmost dignity, respect and excellence. VA is aware that users of the Choice Program have identified aspects of the law that are presenting challenges, resulting in confusion for Veterans, or the Program not working for Veterans as well as it needs. VA also recognizes that early utilization of the Choice Program has not been as robust as expected. This may be due to a number of factors, including Veterans, providers, and VA employees not understanding how the Choice Program works. VA has been, and continues to, eagerly seek feedback on the program from all our stakeholders, including Veterans, Veterans Service Organizations, our employees, and Congress, and we are working diligently to address these challenges. VA looks forward to turning these challenges into opportunities to improve our care and services, but, in some areas, we will need assistance from Congress and stakeholders.

As we approach the end of FY 2015, we are still gathering information about the resources required, the number of Veterans who have used and will continue to use the provisions of the Choice Act to seek non-VA care, and how much that care will cost. On July 31, 2015 P.L. 114-41 was signed into law providing VA the budget flexibility we requested to ensure that we have the right resources at the right places at the right time to provide Veterans with the timely care they need and to provide it wherever they choose to receive it.

Question 10: I've heard that some VA hospitals are looking at converting their energy supply to gas from electricity. I understand that the Atlanta VA hospital is "studying" a possible conversion. Any type of conversion could cost millions in capital costs alone. What is the thought process and analysis on this decision?

VA Answer: The Atlanta VA Medical Center (VAMC) is in the process of installing a combined heat and power system, known as CHP. The VAMC central plant needed to be replaced. VA evaluated a number of options and selected the current system, which is much more efficient than a traditional central plant. Upon installation, the CHP system is projected to save American taxpayers approximately $7 million more over its lifetime compared to the alternatives.

This project will use natural gas to generate enough electricity on-site to power the facility, and will capture the heat produced during this generation to make "free" hot water and steam to help meet VAMC needs. The electrical utility grid will provide backup power. The project will be able to use biogas, a renewable fuel, as appropriate supply becomes available. The VAMC also has conventional emergency generators in accordance with VA policy.

The advantages of this approach are many. First, the facility will avoid about $2 million per year on utilities. By generating electricity and using the waste heat on-site, this project will allow the VAMC to reduce significantly the amount of greenhouse gasses (GHG) emitted by its operation. If VA is successful in acquiring biogas, harmful GHG emissions will be even further reduced. Additionally, this project enhances the facility's resilience in the event of a natural or man-made disaster, helping to ensure its ability to continue to serve Veterans and the community at large in emergency situations.

Question 11: During our last conversation you mentioned that there has been 18,000 sqft of space at Martin Army that would be allocated for a VA clinic? There was to be an initial allocation of 10,000 sqft followed by 8,000 sqft a few month later. As you know this is something that I have been asking for, for years. Can you provide me an update as to the status of this transition?

VA Response: The Martin Army Community Hospital (MACH) has vacated 19,000 square feet of space in Fort Benning, GA. This space is now available for use by the Central Alabama Veterans Health Care System (CAVHCS). VA and MACH are finalizing a Memorandum of Understanding which addresses the space requirements

and includes the provision of Pharmacy and Diagnostic Imaging services for patient care needs by MACH. CAVHCS is also requesting VA Real Property Services obtain a permit from the DoD for the use of this space. The VACO Patient Aligned Clinical Teams (PACT) Space Design Consultant has evaluated the space and has submitted recommendations for minor renovations to ensure PACT space requirements are met. The current plans are to relocate ten fully functional PACTs, along with the Mental Health/Primary Care Integration Teams, to Building 9214 at Fort Benning. This will fulfill VA requirements to provide Primary Care to the CAVHCS's fastest growing area of Veteran enrollees. CAVHCS and MACH have developed an aggressive timeline for the project. A ribbon cutting ceremony took place on July 8, 2015, and CAVHCS began providing Veterans medical care at the new location beginning on July 6, 2015.

Question 12: We have also talked in length about the selection of the VA clinic in North Columbus, GA and the questions of unethical actions in regards to its selection. What have you been able to find out in regards to the selection of the property and if it is truly the best location to service our veterans?

VA Response: The Columbus Clinic will require a lease of 55,000 usable square feet to encompass 71 staff members. The Central Alabama Veterans Health Care System requires areas that are accessible to public transportation and shopping areas, to include pharmacies (local contracted service) for filling of prescriptions received during outpatient visits. Preliminary market research was completed at the facility level. Numerous areas within a 3-mile radius of the Army's North Clinic have the potential to accommodate our build-to-lease needs. This allows the potential of joint shared services with the Army's North Clinic.

Initial offers were reviewed and Technical Evaluation Board (TEB) managed by the Office of Construction and Facilities Management completed the evaluation the week of January 12, 2015. The TEB is a group of qualified individuals responsible for evaluating the technical proposals. Subsequent steps include conducting negotiations, requesting, receiving and evaluating revised proposals, and conducting a pre-award clearance and vetting process.

VA currently anticipates awarding this lease by October 2015. Once the contract is awarded, VA anticipates it will take 24 months to complete post award design, construction, and activation that will prepare the facility for occupancy.

13. In its September 4, 2013 letter to Rep. Ann Kirkpatrick, the VA provided information on third party billings and collections for FY07 through FY12.
The VA provided figures on:

A) Total billings during that period
B) Total collections during that period
C) Percentage annual increase in billings
D) Percentage annual increase in collections

E) Percentage of total collections during that period
F) Collection rate for billings over $1000 during that period
G) Collection rate for billings under $1000 during that period

(1) Do you have comparable figures for FY13 and FY14?
The VA cannot determine collection rates for small (under $1000) and larger (over $1000) claims without data on the value of small and larger claims that were billed and collected.

Please provide those annual figures for small and larger claims (both billed and collected) for the entire period of FY06 through FY14 (See items (A) and (B) above.)

Example:

If the collection rate for billings over $1000 (see F) was 40%, then the VA knew that it collected $40 for billings of $100. It would be helpful to find out what part of (A) were small claims and what part of B were small claims. The VA cannot provide accurate information on (F) and (G) without knowing how much of (A) and (B) were small claims and how much were larger claims.

- Find out in regards to the selection of the property and if it is truly the best location to service our veterans?

VA Answer:

A) Total amount the VA sought in third party billings from FY 2006 to FY 2014 and the percent of these billings from bills over $1,000 and under $1,000 are as follows:

Fiscal Year	Total Third Party Billings	Percent of Billings Over $1,000	Percent of Billings Under $1,000
2006	$2,779,839,772	58.33%	41.67%
2007	$3,325,052,175	58.79%	41.21%
2008	$4,107,259,321	64.20%	35.80%
2009	$5,290,964,587	67.53%	32.47%
2010	$5,490,122,279	66.36%	33.64%
2011	$5,775,314,495	64.82%	35.18%
2012	$5,556,546,698	66.05%	33.95%
2013	$5,547,089,415	66.46%	33.54%
2014	$6,111,844,928	69.33%	30.67%

B) Total VA collections from these third parties from FY 2006 to FY 2014 and the percent of these collections from bills over $1,000 and under $1,000:

Fiscal	Total Third Party	Percent of	Percent of

Year	Collections	Collections Over $1,000	Collections Under $1,000
2006	$1,095,810,128	56.08%	43.92%
2007	$1,261,345,593	55.62%	44.38%
2008	$1,497,448,632	60.48%	39.52%
2009	$1,843,201,251	65.36%	34.64%
2010	$1,904,031,955	64.98%	35.02%
2011	$1,799,951,647	63.78%	36.22%
2012	$1,847,530,762	65.48%	34.52%
2013	$1,980,278,543	65.79%	34.21%
2014	$2,198,744,052	70.01%	29.99%

Note: Percent of collections from small and large claims were estimated by analyzing closed bills in VistA Data Extract (VDE) source.

C) The percentage increase in billings for each year compared with the previous year's billing.

Fiscal Year	Total Third Party Billings	Percent (%) Change from Prior Fiscal Year
2006	$2,779,839,772	-
2007	$3,325,052,175	19.6%
2008	$4,107,259,321	23.52%
2009	$5,290,964,587	28.82%
2010	$5,490,122,279	3.76%
2011	$5,775,314,495	5.19%
2012	$5,556,546,698	-3.79%
2013	$5,547,089,415	-0.2%
2014	$6,111,844,928	10.2%

D) The percentage increase in collections each year compared with previous year's collections.

Fiscal Year	Total Third Party Collections	Percent (%) Change from Prior Fiscal Year
2006	$1,095,810,128	-
2007	$1,261,345,593	15.1%
2008	$1,497,448,632	18.7%
2009	$1,843,201,251	23.1%
2010	$1,904,031,955	3.3%

2011	$1,799,951,647	-5.5%
2012	$1,847,530,762	2.6%
2013	$1,980,278,543	7.2%
2014	$2,198,744,052	11.0%

E) The percentage of collections for each year from FY 2006 to FY 2014.

Fiscal Year	Percentage of Collections
2006	44.3%
2007	46.9%
2008	43.7%
2009	41.1%
2010	39.3%
2011	35.7%
2012	36.2%
2013	39.6%
2014	40.5%

F) The collection rate for claims over $1,000 for each year from FY 2006 to FY 2014.

Fiscal Year	Collection rate for Claims over $1,000
2006	41.4%
2007	44.5%
2008	42.2%
2009	40.9%
2010	39.2%
2011	35.8%
2012	36.5%
2013	40.9%
2014	41.6%

G) The collection rate for claims under $1,000 for each year from FY 2006 to FY 2014.

Fiscal Year	Collection rate for Claims under $1,000
2006	48.7%
2007	50.3%
2008	45.1%
2009	41.3%

2010	39.5%
2011	35.5%
2012	35.5%
2013	39.1%
2014	38.4%

[Questions for the Record submitted by Congressman Farr for the Honorable Robert A. McDonald follows:]

Question 1: What is the VA's current rate of procurement and retention of nationally qualified Mental Health Practitioners?

VA Answer: For occupations that are considered exclusively "mental health"*, VHA has experienced a net onboard increase of 67 employees to date in FY 2015 (through February 28, 2015) compared to September 2014 for a total onboard staffing level of 10,148 employees in these occupations. This equates to an overall 0.66% increase. *Mental Health occupations for this analysis include Psychiatrists, Psychologists, Marriage and Family Therapists, Licensed Professional Mental Health Counselors, and Mental Health Nurses, Practical Nurses, and Nursing Assistants. This does not include Social Workers and other occupations not specifically designated as mental health and therefore does not represent the total number of employees who provide mental health care and services in VHA. Data Source: PAID via HR Employee Cube; excludes Intermittent, Non-Pay, Medical Resident, and Allied Health Trainees with assignment codes T0-T9.

Onboard Employee for VHA, FT/PT, Non-Med Resident, Pay, Non-Trainees (Month)

		SEP-FY14	FEB-FY15	Net Onboard Increase
0101 Social Science	06 MARRIAGE FAMILY THERAPIST	114	115	1
0101 Social Science	17 LICENSED PROF MENTAL HEALTH COUNSELOR	115	132	17
0180 Psychology	0180 Psychology	5,064	5,106	42
0620 Practical Nurse	05 PSYCHIATRIC PRACTICAL NURSE	443	447	4
0621 Nursing Assistant	08 PSYCHIATRIC NURSING ASST	662	642	(20)
0610 Nurse	92 NURSE SUPV PSY SVC	4	8	4
0610 Nurse	N4 NP MENTAL HEALTH SUD	410	422	12
0610 Nurse	N8 CNS-MH/SUD	165	162	(3)
0602 Medical Officer	31 PSYCHIATRY	3,104	3,114	10
Total Mental Health Occupations		10,081	10,148	67

Excludes Social Workers and other occupations not specifically designated Mental Health
Data Source: PAID via HR Employee Cube; excludes Intermittent, Non-Pay, Medical Resident, and Allied Health Trainees with assignment codes T0-T9

Monthly Distinct Employee for Total VHA Losses (not including intra-VHA), FT/PT, Non-Me
Resident, VHA, Pay, Non-Trainees (FY)

		Losses thru Feb 2015	Hires thru Feb 2015	Net Gains
0101 Social Science	06 MARRIAGE FAMILY THERAPIST	4	4	0
0101 Social Science	17 LICENSED PROF MENTAL HEALTH COUNSELOR	5	21	16
0180 Psychology	0180 Psychology	132	172	40
0620 Practical Nurse	05 PSYCHIATRIC PRACTICAL NURSE	17	23	6
0621 Nursing Assistant	08 PSYCHIATRIC NURSING ASST	23	25	2
0610 Nurse	92 NURSE SUPV PSY SVC	0	0	0
0610 Nurse	N4 NP MENTAL HEALTH SUD	19	25	6
0610 Nurse	N8 CNS-MH/SUD	4	1	-3
0602 Medical Officer	31 PSYCHIATRY	91	113	22
Total Mental Health Occupations		295	384	89

Excludes Social Workers and other occupations not specifically designated Mental Health
Data Source: PAID via HR NOA Cube; excludes Intermittent, Non-Pay, Medical Resident, and Allied Health Trainees with assignment codes T0-T9

Question 2: The Committee remains acutely concerned that the VA has a shortage of mental health providers and finds it extremely troubling that the VA ignored the committee directive in the FY15 report that requested the VA to 'explore the possibility of using a grouping of a national accrediting body' as a viable alternative. The Committee found both the VA report and the answers provided by the VA witnesses at the FY16 budget oversight hearing to be equally non responsive. Please explain/identify the steps the VA is taking to reform its accrediting policy without further delay?

VA Response: VA appreciates the committee's request that VA explores the possibility of utilizing a group of Regional Accrediting bodies as an alternative to requiring that an individual has graduated from a program accredited by the Commission on Accreditation for Marriage and Family Therapy (COAMFTE). VA has explored this possibility, and believes that the current accreditation requirements for Marriage and Family Therapists (MFTs) are appropriate. These standards help ensure that Veterans receive the highest quality marriage and family counseling services.

While regional accrediting bodies are recognized by the Council for Higher Education Accreditation (CHEA), it is important to understand that these regional accrediting bodies accredit academic institutions; but do not examine the quality of education provided in a specific program. If an individual has not graduated from a program that has been COAMFTE accredited, VA cannot be assured that the provider has graduated from a program that has met professional standards developed by a national consensus of professionals in the Marriage and Family field. It is important to note, the qualification standards for each of the other core mental health professions (Psychology, Psychiatry, Social Work, Nursing, Licensed Professional Mental Health Counseling) also require that an individual in that discipline has graduated from a program that is accredited by

an approved accrediting body that accredits training programs in that discipline. Thus, the standards for MFT graduate program accreditation are similar to and no higher than the standards for graduate program accreditation for other mental health professions in VA.

Question 3: What partnerships between the VA and local law enforcement officers and VSO's exist in helping support suicidal veterans?

VA Answer: Each VA Medical Center has at least one Veterans Justice Outreach Specialist who acts as a liaison with local criminal justice partners, including law enforcement. **Moreover,** VA Suicide Prevention Coordinators (SPCs) frequently offer Operation S.A.V.E. training to local law enforcement agencies. Operation S.A.V.E. is a VA-designed, in-person crisis intervention training that: helps participants learn the **S**igns of suicide; **A**sking about suicide; **V**alidating feelings; and **E**ncouraging help and **E**xpediting treatment. Many SPCs have developed relationships with local law enforcement and provide information on resources available through local VAs, as well as Veterans Crisis Line materials such as wallet cards and magnets. Nationally, VA collaborates with CIT **(Crisis Intervention Team)** programs, which are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. VA collaboration with CIT is built on strong partnerships between law enforcement, mental health provider agencies, and individuals and families affected by mental illness. VA SPCs have engaged with local law enforcement throughout the country as a part of CIT programs.

VA has partnered with VSOs both nationally and locally to support suicidal Veterans. Nationally, VA's Suicide Prevention office has developed strong collaborations with VSO leadership to address Veteran suicide prevention efforts. Through frequent conferences, meetings, and national trainings on suicide prevention, VA's Suicide Prevention office leadership offers and solicits feedback on VSOs' concerns for Veterans who may be in crisis. Locally, VA SPCs have developed relationships with local VSO branches to provide Operation S.A.V.E. training as well as to distribute materials and information on VA's Suicide Prevention program, including information on the Veterans Crisis Line.

Question 4: When law enforcement apprehends a suicidal veteran, who should they be in contact with at the VA regarding the immediate subsequent care of these individuals?

VA Response: When law enforcement encounters a suicidal Veteran, they should bring the patient to VA's emergency department (ED), where they would give a report to the ED's triage nurse just as they would with any other patient they are delivering to an ED. The ED physician would then be responsible for assessing the patient and calling the psychiatrist on tour or on call to further evaluate the patient or concur admission depending on what the ED physician finds on exam. Suicide risk assessments are conducted, which include questions related to the patient's thoughts of suicide, plans related to suicide, and intent to die by suicide.

Question 5: Were sufficient funds requested in the FY 16 budget to manage both the current and anticipated influx of claims at the VBA?

VA Answer: In FY 2014, VBA outlined a plan to right-size its workforce by adding 1,618 FTE necessary to meet Veterans' expectations for non-rating decisions, fiduciary services, and appeals decisions. VBA is grateful for funding in FY 2015 to hire an additional 250 FTE to process appeals, address non-rating workload, and conduct fiduciary field examinations. VBA is asking for funding in FY 2016 to hire an additional 770 FTE. The request for 770 FTE includes 200 appeals processors, 320 non-rating claims processors, 85 fiduciary field examiners, and 165 support personnel. VBA is continuing to analyze requirements to fully address the anticipated needs of our Veterans.

Question 6: Please submit for the record a detailed plan for elimination of the Appeals Court Backlog including the necessary resources required to achieve functional 0.

VA Answer: VA is committed to providing the care and services our Veterans have earned and deserve, especially in regard to improving VA's appeals process to be more timely and efficient. VA recognizes that some Veterans are waiting too long for a final resolution of appeals, and no Veteran should endure a lengthy delay for the benefits they have earned and deserve. In FY 2014, VBA completed a record-breaking 1.32 million claims. With this increased production, the VA's volume of appeals has grown proportionately. Currently, there are approximately 408,000 appeals pending at various stages in the multi-step appeals process, which divides responsibility between VBA and the Board of Veterans' Appeals (the Board). The Board controls approximately 75,000 of those appeals. Approximately 308,000 of these appeals are pending with VBA. An additional 25,000 appeals for which VBA has issued a statement of the case are currently awaiting a decision by the claimant on whether to pursue a formal appeal.

VA is exploring a series of measures within existing authorities to improve the appeals process, as stated in the attached VA Strategic Plan to Transform the Appeal Process, which VA released to Congress on February 26, 2014. The plan is focused on employee training, tools, and assignment of work; streamlining the appeal process; and implementing modern technology solutions. On March 24, 2015, VA implemented the standard appeals forms rule, which requires claimants to use VA Form 21-0958, Notice of Disagreement, to submit an appeal. However, the plan noted that VA cannot fully transform its appeal process without stakeholder support. More recently, we partnered with Veterans Service Organizations to examine potential long-term strategies to address the appeals workload. Those discussions led to the introduction of H.R. 800, the Express Appeals Act, which would authorize a pilot project to test an optional streamlined appeals process. Finally, VA's FY 2016 budget request includes a number of legislative proposals, such as closing the evidentiary record, clarifying the Board's jurisdiction to consider appeal-related evidence in the first instance, shortening the appeal filing period from 1 year to 60 days, and eliminating direct payment of fees from VA to accredited agents and attorneys, which would provide VA some assistance in

addressing the appellate workload, while also ensuring that future Veterans have an efficient process that meets their need for timely final decisions on their claims.

VA greatly appreciates the support and resources that Congress has provided over the past two fiscal years. The Board has 640 employees processing appeals, up from 532 employees in FY 2013, including a substantial growth in the Board's attorney staff. With this 20-percent increase in staffing, coupled with increased efficiency, the Board was able to boost its output by 32.5 percent, from 41,910 decisions in FY 2013 to 55,532 decisions in FY 2014.

VBA has approximately 950 employees dedicated to processing appeals in regional offices and 190 employees at the Appeals Management Center. VBA is grateful for funding in FY 2015 to hire 100 appeals FTE and is asking for funding in FY 2016 to hire another 200 appeals FTE. These additional FTE will allow VBA to increase its focus on appellate workload and begin to reduce the inventory of pending appeals. In addition, because historically approximately 9-10% of the decisions made by the Board are appealed to the Court of Appeals for Veterans Claims, and a number of those cases are appealed to the U.S. Court of Appeals for the Federal Circuit, a corresponding increase in FTE is needed to enable the Office of General Counsel to handle the anticipated growth in appeals work.

However, VBA believes that without legislation to streamline the appeals process, it will be unable to make substantial progress in this area. We are thankful for the increased dialogue on the VA appeals process, and look forward to continuing to work with all stakeholders to carefully examine potential areas of reform.

Attachments

Name	Description
140226 SVAC Appeals Report.pdf	

Question 7: Veterans are experiencing unnecessary wait times between authorization to use the Choice card and ability to schedule an appointment. How are you working, specifically with TriWest, to deliver the 48 hour turnaround that veterans were promised?

VA Answer: VA is working to increase efficiencies when submitting the eligibility files to the two Third Party Administrators (TPAs), TriWest and HealthNet, for the 30-day Veterans Choice List (VCL) and Veterans eligible based on their place of residence. On March 10, 2015, VHA began sending files to the TPAs on a daily basis for wait

times. VHA is working on improvements for the eligibility based on their place of residence. In accordance with the Choice Program contracts with the TPAs, the TPAs must authorize care and obtain an appointment for the Veteran within 5 days, and appointments for Veterans eligible based on wait times are required to take place within 30 calendar days of the "clinical need" date, as detailed in the consult provided by the VA Medical Center (VAMC), or if no such date is identified, the Veteran's preferred appointment date. For Veterans eligible based on their place of residence, the contract provides that the appointment shall take place within 30 calendar days of the Veteran's preferred appointment date.

Question 8: With regard to homelessness, is the budget request of FY16 sufficient for reaching your goal of 'functional 0' by the end of CY15?

VA Answer: VA, along with the United States Interagency Council on Homelessness (USICH), U.S. Department of Housing and Urban Development (HUD), U.S. Department of Labor (DOL), and other federal, state, local, and nonprofit partners, is undertaking an unprecedented campaign to make sure every Veteran is able to obtain permanent housing and every Veteran who is at risk of homelessness remains housed. This campaign has been successful so far—homelessness among Veterans is down by 33 percent since 2010, and with continued focus from federal, state and local partners, we are on a path to end veteran homelessness by the end of 2015. The FY 2016 budget ensures continued investment in programs that will sustain and continue this progress.

Question 9: With an increase in homeless female veterans, is the FY 16 budget request sufficient to reach functional 0 by the end of calendar year 2015?

VA Response: Recent interagency analysis, current trends, and our projections indicate that, with continued focus from Federal, State and local partners, we are on a path to end homelessness by the end of 2015. The attachment provides an overview of current efforts that focus on homeless female Veterans.

Question 10: Given the recent passage of the Clay Hunt Suicide Prevention Act, the VA is required to implement annual mental health evaluations. How many Mental Health providers does the VA need to fully comply with this new law? Please identify in the F16 budget the line item for mental health providers for the annual evaluations required under the Clay Hunt Suicide Prevention Act.

VA Answer: VA is working to implement the requirements of the Clay Hunt Suicide Prevention Act in conjunction with our existing suicide prevention programs. The VA's Clay Hunt Act Implementation Committee is reviewing each section of the law to develop a specific plan for carrying out the requirements of the Act. At this point the Committee does not have an estimate regarding staffing requirements and there are currently no line items in the FY2016 budget for mental health providers related to implementation of the Clay Hunt Act or for the annual evaluations of VA's mental health programs that are required by the Act.

Question 11: How is the VA working with the Services and the States to help transfer military accreditation to the civil workforce?

VA Answer: VHA and the Veterans Employment Service Office (VESO) collaborate on multiple efforts to reach out to transitioning military Veterans about employment opportunities with the Department of Veterans Affairs (VA). The VESO's VA for Vets initiative helps Veterans and transitioning military service members find federal careers by providing a website with comprehensive resources for transitioning military personnel, as well as regional employment coordinators who can directly assist Veterans with developing application packages that translate the extensive skills they obtained in the military to civilian employment.

Veterans Health Administration's (VHA) National Recruitment Program (NRP) provides an in-house team of skilled professional recruiters employing private sector best practices to fill VHA's most critical clinical and executive positions. The national recruiters, all of whom are Veterans, work directly with Veterans Integrated Service Network Directors, Medical Center Directors, and clinical leadership in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs. Transitioning military health care personnel are connected directly to a national recruiter who can match their clinical and leadership backgrounds with existing vacancies.

In FY 2014, the team successfully placed 100 Veterans in clinical positions at VHA facilities nationwide; 16 of those Veterans filled clinical and executive leadership roles at VA hospitals. VHA also coordinates attendance at national events to target recruiting of military health care personnel. Staff attended the Joint Forces Pharmacy Seminar on October 19-22, 2014, receiving over 40 leads. VHA has also partnered with VESO to promote additional events targeting transitioning military personnel on the VA Careers website and VHA's Media Plan for FY 2015 has specific national marketing and advertising buys targeted towards recruitment of transitioning military personnel.

Question 12: Please submit for the record ways in which the VA can partner with nonprofit organizations [like Ride to Recovery] to assure they have the resources to expand their services to more veterans.

VA Answer: In general, VA uses a number of different strategies to collaborate, or partner, with non-profit organizations depending on the type of services being offered, collaboration being pursued, needs of Veterans and VA, and resources that are required to enable the collaboration.

VA often provides information and materials to non-profits on VA benefits and services, including ways that community organizations can provide support that complements VA. VA connects community organizations, to include non-profits, with local VA facility representatives who are subject matter experts (SMEs) in their specific field of service or support in order to establish and maintain strategic communications. VA SMEs meet with non-profit organizations to discuss and explore new ways to collaborate. Local VA representatives inform non-profits of resources that may be available to them within their community. Local VA facilities include community organizations in VA hosted events, such as Welcome Home Events, Mental Health Summits, Homeless Stand Downs, and other events where they can increase awareness of Veterans programs.

VA also provides information on available grant opportunities, such as the recently announced (March 27, 2015) Notice of Funding Availability for up to $8 million in grants for non-Federal government entities with significant experience in managing large-scale adaptive sports programs for persons with certain disabilities. The grant program provides adaptive sports opportunities for disabled Veterans and disabled members of the Armed Forces and can be found at www.grants.gov. Organizations can register to receive email notifications for Federal funding opportunities at the website too.

A variety of these strategies may be used based on the specific request from a potential non-profit partner, the collaboration they are pursing, and the needs of Veterans and Veterans Affairs.

Attachments

Name	Description
Ride 2 Recovery The Resilient Warrior.pdf	
Ride 2 Recovery Womens Initiative.pd	

Question 13: Please submit for the record, a plan that outlines the conveyance of underutilized or unutilized VA properties to alternative governmental entities or programs.

VA Response: VA presently has six active disposals of real property (see table below). This list incorporates permanent disposals, inter-agency transfers, and temporary fed-to-fed conveyances involving land and buildings (permits). VA continuously evaluates vacant and underutilized properties for reuse or disposal.

North Little Rock, AR	State Home Land Transfer (30 acres)	State Home transfer authority
Ft. Thomas, KY	Direct Disposal of Historic Quarters	Special Legislation
Pittsburgh, PA	State Home Land Transfer (10 acres)	State Home transfer authority
Walla Walla, WA	State Home Land Transfer (10 acres)	State Home transfer authority
Bronx, NY	Compensated Work Therapy Home (CWT) [0.046 acres + improvement]	CWT authority
Staten Island, NY	Vacant lot (0.3 acres)	GSA Excess

[Questions for the Record submitted by Congressman Jolly for the Honorable Robert A. McDonald follows:]

More than one year ago, VA awarded two contracts to operate the new Patient-Centered Community Care Program (PC3), which VA describes as "a program that contracts with vendors to develop a network of health care providers to deliver covered care to Veterans when local VA Medical Centers cannot readily provide the needed care to Veterans due to demand exceeding capacity, geographic inaccessibility or other limiting factors." As I understand the program, it was designed to ultimately replace VA's traditional "Fee Basis" program (to include direct contracting) with a more uniform set of requirements and consistent rates paid at or below Medicare. In the spring of 2014, challenges concerning VA's management of access to care in its facilities, and the wait times associated with those challenges became very public. Congress responded by passing the Veterans Access, Choice, and Accountability Act of 2014, which created the Veterans Choice Program.

Question 1a: This program, too, reimburses providers at or below Medicare rates. Can you comment on to what extent the VA continues to rely on its traditional Fee Basis program and local contracts when providing care in the community versus using the PC3 and Veteran's Choice Program?

VA Answer: Today, the Non-VA Medical Care Program is widely used in order to provide timely and specialized care to eligible Veterans. Non-VA Medical Care is hospital care and medical services provided to eligible Veterans outside the VA Health Care System when the required treatment or services are not feasibly available or geographically accessible at the nearest VA Health Care Facility. Non-VA care is critical for Veterans. Between May 2014 and January of this year, alone, we obligated almost $7 billion for non-VA care to Veterans under programs other than the Choice Program. While PC3 and Choice are integral parts of VA's strategy to provide access to care, VA will always require the traditional non-VA medical care authorities, contracts for non-VA medical care, and other special emphasis programs to provide the necessary and specialized medical care for our Veterans. It is important to note that the Choice Program was established as a temporary program to improve Veterans' access to care.

Question 1b: What percentage nationally of VA's community care authorizations are still provided through Fee Basis and local contracts as compared to PC3 or the Choice Program?

VA Answer: National utilization of PC3 since full implementation has been approximately 10% to 12%. This analysis excludes several authorization types that would not be eligible for PC3 care, such as Dental, Homemaker/Home Health Aide, Dialysis, and Compensation and Pension authorizations.

Question 1c: Are some facilities or VISNs higher users of the new programs as compared to others?

VA Answer: Yes, in February 2015 some facilities had utilization rates of PC3 over 50%, whereas other facilities had utilization near zero percent.

Question 1d: Why is the Fee Basis program still necessary and how much longer does VA anticipate needing that program?

VA Answer: VA Medical Centers use the Non-VA Medical Care Program to provide medical services that are not feasibly or geographically available within the VA Health Care System or any other VHA or Federal facility. VA will always require the traditional non-VA medical care authorities, contracts for non-VA medical care and other special emphasis programs to provide the necessary and specialized medical care for our Veterans.

Question 1e: What on average does the VA pay to health benefits managers under the CP3 and Vets's Choice models versus what it is commonly paying providers in the community when using Fee Basis or local contracts? Fee Basis program still necessary and how much longer does VA anticipate needing that program?

VA Answer: PC3/ Choice Contractors are paid based on a negotiated Medicare percentage for any authorized care provided. Contract pricing can be below, at, or above CMS as a percentage. Reimbursement rates for non-VA medical care are governed by Federal regulation and are based on Medicare rates. In the absence of an applicable Medicare rate, VA reimburses providers via the VA Fee Schedule amount. To summarize:

- The applicable Medicare fee schedule or prospective payment system amount ("Medicare rate") for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities).
- In the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver.
- VA Fee Schedule amount for the period in which the service was provided. The VA Fee Schedule amount is determined by the authorizing VA medical facility, which ranks all billings (if the facility has had at least eight billings) from non-VA facilities under the corresponding procedure code during the previous fiscal year, with billings ranked from the highest to the lowest. The VA Fee Schedule amount is the charge falling at the 75th percentile. If the authorizing facility has not had at least eight such billings, then this paragraph does not apply.

Question 2: I recognize that the goal of everyone here is to create a more streamlined approach to providing care in the community that relies on consistent processes throughout all of VA's sites of care and reimburses providers at consistent rates. However, there are still several different programs operating simultaneously seeking to achieve the same goal. Can you provide some insight into the VA's long-term plans for the fate of these programs?

VA Answer: VA's long-term plan is to integrate the various Non-VA Medical Care programs into a single managed care program that is part of a Veteran's continuum of care. The VHA Chief Business Office will be putting together a team to study and make recommendations related to how best to integrate this managed care program and ensure it is coordinated with care provided within VA facilities.

Question 3: As it relates to the Center for Verification and Evaluation, can you elaborate on the seemingly increasing divergence between SBA interpretations and VA interpretations of ownership and control?

VA Answer: Because of the public perception of significant differences between the VA and Small Business Administration (SBA) rules, the Center for Verification and Evaluation (CVE) did a very careful review of its regulation and how CVE applies and interprets the regulation. We also examined selected SBA decisions on protests of Service-Disabled Veteran-Owned Small Business (SDVOSB) status, and SBA Office of Hearings and Appeals (OHA) decisions since 2007 on appeals of SBA status protest decisions.

VA's regulation on ownership and control (38 CFR Part 74) was in fact derived from SBA's rules on SDVOSB eligibility in 13 CFR Part 125. We also incorporated relevant provisions from SBA's certification-based programs, particularly the 8(a) Business Development program (13 CFR Part 124). We took this approach since OHA, in fact, has relied on control criteria in its 8(a) program to guide it in its SDVOSB status protest matters (see, for example, In the Matter of Eason Enterprises OKC LLC, et al., SBA No. SDV-102 (2005).

Our review indicated SBA's rule and ours differ in a limited number of ways.

Differences Required by Statute. VA's regulations apply to all Veteran-Owned Small Businesses (VOSBs), not just SDVOSBs. Subsections (f) and (l) of title 38, United States Code, section 8127, provide for the verification of VOSBs as well as SDVOSBs. Since there is no corresponding Government-wide VOSB program, SBA's rule applies only to SDVOSBs.
Second, VA's regulation provides for surviving spouses to own and control a firm upon the death of its SDVOSB owner under certain conditions. This provision is required by 38 USC 8127(h). SBA has no comparable provision.

Difference Required by Program Criteria. VA's rule requires a VOSB to notify CVE of a change in ownership (38 CFR 74.3(e)). CVE's role is to verify ownership and control, and that verification is good for two years.
SBA does not conduct verification for its SDVOSB program, and a firm's self-representation at the time it submits its initial offer on a specific contract is deemed sufficient unless challenged in a formal protest by a competing offeror or by a contracting officer. A change in ownership could result in the firm being unable to maintain its representation as an SDVOSB and, if no longer eligible, subject to protest on a specific contract on the grounds of ownership and potentially control.

VA's verification program shares some similarities with certain SBA programs that are not based upon self-representation. VA's regulation, like SBA's 8(a) program, has an application process, and similar to VA, changes to ownership must be communicated to the SBA and approved. In addition, SBA's HUBZone program, which also requires the submission of an application and subsequent certification, requires qualified firms to notify the SBA of "any material change that could affect its eligibility" (13 CFR 126.501). Failure to report any such material change can result in de-certification.

Difference Based on Normal Commercial Practices. SBA regulations, like VA regulations, require unconditional ownership of an SDVOSB by one or more service-disabled Veterans. Office of Hearing and Appeals cases require ownership to be without restriction on the transfer of ownership (such as right of first refusal by the other owners), since such a restriction would amount to a condition.
CVE does not prohibit restrictions on the transfer of ownership as they are part of normal commercial practices. VA departed from SBA's interpretation following the U.S. Court of Federal Claims decision applying to rights of first refusal (Miles Construction LLC v. United States, 108 Fed. Cl. 792 (2013)). Notably, the SBA was not a party to this case, which involved interpretation of the VA regulation. The VA rule is more permissive than the SBA rule and allows Veteran owners additional flexibility to conform to normal commercial practices.

Potential Difference. VA has denied verification to applicants where a non-Veteran may determine a decision made by a firm's board of directors. If Veteran members of a board vote differently on a given issue, and a non-Veteran board member becomes the deciding vote, the Veterans do not fully control the firm as required by the verification program.
Our review of SBA and OHA decisions did not indicate any cases where SBA has directly addressed this issue, nor does SBA's regulation directly address it. We have been informed by the SBA that its interpretation would allow split voting, but in the absence of specific cases this has not been made explicit.

Conclusion. Based on this review, VA believes the perception of significant differences between the two sets of regulations is largely the result of past confusion that can be, and has been, addressed through CVE's Verification Assistance Briefs. It is our belief that the more information is provided up-front, the more our customers will understand expectations and be prepared to address them. VA will continue to improve its outreach in this area.

[Questions for the Record submitted by Chairwoman Lee for the Honorable Robert A. McDonald follows:]

Thank you, Chairman Dent and Ranking Bishop, for holding this morning's important hearing.

Thank you also to Secretary Robert McDonald for joining us here this morning.

As the daughter of a veteran, I believe we have a moral responsibility to keep our promise to the people who have served our nation. American veterans, service members and their families deserve our full support and I look forward to discussing how we can assist you in ensuring you have the resources you need to achieve the goal of serving those who have served us.

As a nation, one of our most pressing priorities should be providing good-paying jobs and healthcare for veterans. There continues to be a whole host of issues that affect our Veterans and I want to discuss how this budget will help those who served our country in uniform. So I would like to ask a few questions regarding mental health and job training, specifically in the field of renewable energy.

Question 1 (Oakland VARO Justification for these abysmal times in claims processing): I have some very grave concerns regarding the funds already being spent on updating our veteran's claims backlog. As you know, the Oakland veterans Affairs Regional Office is in my district, and year after year we have seen money appropriated to fix this backlog, and not only does it still remain- but veterans who deserve their benefits are dying before they can receive them because we can't process the paperwork.

The Department of Veterans Affairs, Office of Inspector General (OIG), issued the Review of Alleged Mismanagement of Informal Claims Processing at VA Regional Office, Oakland, California. They found - Dating back to the early 1990s - the VA had not acted on thousands of informal claims due to prioritization of formal claims, and then at some point those informal claims were lost. In 2012, VA discovered those lost claims (13,184 informal claims) and began a process to review them and take action as necessary. Record keeping was poor, and the OIG could not confirm the original count of 13,184 unprocessed informal claims from 2012, the 2,155 identified as requiring additional review or action, or that only 537 were remaining at the time of the OIG inspection in 2014.

Because of inadequate processing actions and improper supervision of trainees on the informal claims, veterans did not always receive consideration for benefits to which they may have been entitled.

Further, VARO staff should have sent formal applications for benefits to those

claimants who submitted informal claims. As a result, claimants may not have received accurate benefits payments.

Question: Mr. Secretary, I want to know. How on earth could this happen, and now that you are at the helm, what do you intend to do about this?

VA Answer: In FY 2012, the Veterans Benefits Administration (VBA) found that the Oakland Regional Office (RO) was maintaining a file cabinet of duplicate copies of approximately 13,000 informal claim documents. Oakland was inappropriately using an outdated local procedure for keeping copies of informal claims. VBA directed that all documents be reviewed to determine if any needed corrective actions. Oakland employees completed the initial review of all of the documents with the exception of 2,155 documents requiring a review of the associated claim folders housed at off-site storage facilities.

In May 2014, before Oakland had completed all of the 2,155 claim folder reviews, allegations of unprocessed claims were made by former employees on a radio talk show. The documents were re-reviewed in June 2014 to ensure no further action was needed on any of the documents --and then the copies were filed in the Veterans' records.

To further investigate the allegations, VBA requested the assistance of the Office of Inspector General (OIG). The OIG did not find any additional improperly stored claim documents in any areas, as had been alleged by the former employees. The OIG was unable to confirm the actions taken by the Oakland RO on the majority of the 13,000 documents, as only 537 documents were remaining to be reviewed at the time of the OIG investigation was initiated. The copies of all of the other reviewed documents had been filed in the Veterans' claims folders.

In total, 403 documents (approximately three percent of the original 13,000 documents) were identified by the Oakland RO's reviews as requiring additional claims processing actions, the last of which were completed in September 2014. The Oakland RO concurred with the OIG recommendations to improve operations and fully implemented all of the recommendations. The Oakland RO also recently implemented the national centralized mail initiative, which significantly reduces the potential for delayed handling of paper documents. All of Oakland's claim-related mail is now directed to a centralized scanning facility in Janesville, Wisconsin, for conversion from paper to electronic digital format.

In May 2014, Ms. Julianna Boor was appointed as the new Director of the Oakland RO. In her first ten months, Ms. Boor has already made major improvements in service delivery to Northern California Veterans. Under her leadership, the Oakland RO has reduced the inventory of pending claims by over 11 percent from 18,783 claims in May 2014, to 16,658 claims at the end of February 2015. Additionally, the backlog of claims pending more than 125 days has been reduced by 12 percent from 10,047 claims in May 2014 to 8,861 claims at the end of February 2015.

VA also just implemented an important regulatory change to make the claim process easier and more efficient for Veterans through the use of standardized claim and appeal forms. This change, effective March 24, 2015, includes a new *intent to file* process that replaces the informal claim process for applicants who need additional time to gather all of the information and evidence needed to submit their formal application for benefits. This new process protects the earliest possible effective date if the applicant is determined eligible for benefits and helps to ensure anyone wishing to file a claim receives the information and assistance they need. Applicants may notify VA of their *intent to file* a claim in order to establish the earliest possible effective date for benefits if they are determined eligible. An *intent to file* a claim may be submitted in one of three ways:

1. Electronically via eBenefits or Stakeholder Enterprise Portal.
2. By completing and mailing a paper VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*)
3. Over the phone with a VA call center agent or in person with a public contact representative.

Additionally, Veterans may appoint a duly authorized representative, such as a Veterans Service Organization, that can notify VA of a claimant's intent to file using any of the methods listed above. VA will allow individuals up to one year from the date they submit their *intent to file* to complete the appropriate benefit application form. Veterans may wish to use this one-year period to gather evidence necessary to support their claim so that evidence can be submitted along with the application form as a fully developed claim.

Question 3: (Cooperation between the DOD and the VA to ensure service members have access to jobs once they leave the armed forces): I recently introduced the INVEST Act, which gives a tax credit to employers who hire veterans in renewable technologies. This is sensible because so many of our servicemen and women are now trained in green technology.
Our service men and women are being trained in renewable energy because the military has made excellent strides in building bases and other facilities that run on renewable energy, all of which are LEED certified. I would like to share with you an excellent example of cooperation between Navy and Solar companies- to make sure service members are trained and ready to enter the civilian workforce.
On Friday February 13th at Marine Corps Base Camp Pendleton, in a courtyard of Marine barracks covered in solar panels, a group of Marines, the Department of Energy (DOE), interagency partners, the private sector, and NGO partners all gathered to congratulate 17 Marines and 3 Sailors as they graduated from a first-ever one month solar training pilot. The pilot, sponsored by the Department of Energy Sunshot program, was designed to prepare the participants for a future career in the growing solar industry as they transition from the military.

The training pilot included four weeks of instruction, and testing for the North American Board of Certified Energy Practitioners (NABCEP) PV installer certificate. It also included interviews with private sector solar companies including SolarCity, Vivint Solar, Sunrun, SunEdison, and SunPower who are all experiencing significant growth.

Moving forward, the DOE Sunshot pilot program will be sponsoring additional pilots at Ft. Carson, CO and Naval Station Norfolk, VA in the spring.

Together, these pilots will enable refinement of the course curriculum, participant selection, collaboration amongst multiple entities to facilitate training and transition from the military service to the private sector, and pathways to facilitate an enduring course model.

What is your agency doing to make sure that these service members and many more who are being trained with in renewable energy to find jobs once they leave the service?

VA Answer: Servicemembers who are trained within renewable energy can utilize the Veterans Employment Center (VEC) to find related jobs once they leave service. VEC provides transitioning Servicemembers, Veterans, and their families with a single authoritative Internet source that connects them with job opportunities and provides tools to translate their military skills into plain language and build a profile that can be shared in real time with employers. It also allows green industry employers to make commitments to hire individuals in the military community.

VEC's job bank allows users to search over 1.7 million jobs from the private sector and Federal, state, and local governments. The job bank's advanced search function allows

Veterans to narrow their job search by both industry and occupation, providing further assistance to those seeking careers in renewable industries.

Through VEC, the following companies have made significant commitments to hire transitioning Servicemembers, Veterans, and family members seeking to secure competitive employment in renewable industries: Lawrence Livermore National Laboratory; General Electric; Johnson Controls, Inc; Eaton; Trinity Industries, Inc; ManTech International Corporation; Exelon Corporation; Honeywell Technology Solutions; and Nuverra Environment Solutions. Combined, these employers have made a VEC commitment to hire over 23,000 individuals in the military community.

Additionally, on May 8, 2015, the Secretary of Energy, the CEO of the Energy Alliance of Greater Pittsburgh, the Senior Vice President of the Allegheny Conference on Community Development, and senior leaders from the Departments of Energy, Defense, and Labor, and VA will meet. The purpose will be to discuss concrete steps to map the needs of the energy sector in Pittsburgh and specific job opening and/or training opportunities available for Veterans, transitioning Servicemembers, and their families.

In recent years we have had a focus on the major issue of mental illness among our veterans coming home from war. Almost a third of veterans returning from Afghanistan and Iraq confront mental health problems. Approximately 30% of veterans treated in the Veterans health system suffer from depressive symptoms, two to three times the rate of the general population. Unfortunately, many of those who face mental illness turn to substance abuse.

My colleague on the LHHSEd subcommittee, Rep. Chaka Fattah – brought up an interesting point about neuroscience research yesterday. He asked if there was more parity between studies on women and men. Also he asked to have studies done with minority patients in clinical trials so that they are able to use studies that reflect demographics.

Question: I want to know if the VA medical centers, where you do a lot of cutting edge biomedical research is following the same model to diversify in its medical studies? We have Good opportunity here as most studies use a mostly white cohort. Please respond.

Can you please take a moment and walk me through how the VA plans to address mental illness; particularly the link between mental illness and substance abuse?

VA Response: The VA Research Program is committed to ensuring adequate representation of women and minorities in VA research. It is critical to extend the benefits of research to all individuals, regardless of gender, race, or ethnicity and the Office of Research and Development (ORD) strongly encourages VA investigators to include all relevant demographic groups. VHA Handbook 1200.09, Inclusion of Women and Minorities in Research, specifically requires medical centers and Veterans

Integrated Service Network Directors (VISN) to ensure that each facility conducting research within the VISN is in compliance with this policy and has procedural guidelines relating to the inclusion of women and minorities in research. Additionally, ORD has funded the VA Women's Health Research Network, which seeks to build research capacity to augment the efforts of VA researchers focused on women Veterans' health and expand the number of women Veterans involved in VA research.

The attached presentation addresses uniform mental health services within the VA and plans for services to address serious mental illness and substance abuse.

VHA-Mental Health Services

THURSDAY, MARCH 19, 2015.

OVERSIGHT HEARING—DEPARTMENT OF VETERANS AFFAIRS, OFFICE OF THE INSPECTOR GENERAL

WITNESSES

MR. RICHARD J. GRIFFIN, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

DR. JOHN D. DAIGH, JR., CPA, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTION, DEPARTMENT OF VETERANS AFFAIRS

Mr. DENT [presiding]. We will bring this meeting to order. Good morning.

We would like to welcome Mr. Richard Griffin, the deputy inspector general for the Veterans Administration, to discuss his office's oversight efforts at the Veterans Administration.

This is probably one of the most active periods in recent memory for your office, Mr. Griffin, with your audits of whistleblower allegations and the wait list scandal reports that you are required to make to Congress by the Choice Act. You have also had to respond to recent charges that your office has fallen a little bit short on transparency by failing to release some investigative reports.

Members of the subcommittee will no doubt have many questions about the many areas of your oversight, and we understand that you have a previous engagement that requires you to leave at 11:30 this morning, and we will do our best to honor that. But with all the issues, from the wait list scandal to the construction challenges issue at Denver and so many other issues, I look forward to just getting right into this testimony.

At this time I would like to ask our ranking member, Mr. Bishop, if he has any opening remarks that he would like to make?

RANKING MEMBER BISHOP OPENING STATEMENT

Mr. BISHOP. Thank you very much, Mr. Chairman, for yielding.

I believe that the inspector general plays a vital role in ensuring the programs that are implemented actually work and that the funding is spent wisely. The I.G. last year, I think, was tasked with the difficult work of investigating the scandal in Phoenix, about which we were all appalled.

In response to this investigation, which uncovered numerous issues, Congress moved forward on historic legislation, including the Veterans Choice Act, that would improve access to health care for veterans across the nation, which was signed into law in August. While this is an essential first step in addressing the systemic issues that are facing the Department of Veterans Affairs, there is still a lot of work to be done.

And as we move forward, it is critical that the inspector general have the necessary resources to conduct aggressive oversight to en-

sure that veterans are able to receive the health care that they need when they need it. It is vital that we change the culture that has been so infested within the V.A. and to make sure that it doesn't resurface.

No matter what steps the V.A. takes to address the challenges that it faces, it will not be able to move forward if we don't have proper oversight. So I commend you for the work that has been done over the last several months, but there is a lot yet to be done to repair the trust that has really been broken with our veterans and with the American people for the veterans—the V.A. system.

So I look forward, Mr. Chairman and members of the subcommittee, to working with the department to eliminate the issues that are raised by the I.G.

And I thank you, and I will yield back.

Mr. DENT. Thank you.

So, Mr. Griffin, your full statement will be entered into the record. Please introduce Mr. Daigh, who is with you at the witness table, and please summarize your testimony for us. And I know we are going to be interrupted by votes at some point, so we are going to try to move along as quickly as we can.

Mr. GRIFFIN. Thank you.

Mr. Chairman, Ranking Member Bishop, and Members of the Subcommittee, thank you for the opportunity to discuss the work of the V.A. Office of Inspector General.

In fiscal year 2014, our office issued 310 reports, we closed 880 investigations, we made 539 arrests, and we identified $2.3 billion in monetary benefits for a return on investment of $22 for every dollar in I.G. funding. In the first 5 months of fiscal year 2015 alone, the I.G. has recovered in fines, penalties, restitution, and civil judgments, actual money returned to the U.S. government equivalent to 91 percent of our enacted appropriations.

Recoveries since fiscal year 2011 are even more remarkable, with $3.1 billion in recoveries, which represents actual cash recoveries of $5.50 for every dollar spent on the I.G.'s operations.

In the past 6 years we have issued more than 1,700 reports, made more than 3,000 arrests, and provided testimony at 69 congressional hearings. We conducted 400 briefings for Members of Congress and staff and responded to more than 1,300 written requests from various members of the House and the Senate.

This level of productivity and information-sharing with Congress is among the very highest in the I.G. community. During the past 6 years, our work has been recognized by the Council of Inspector General for Integrity and Efficiency with 25 awards for excellence.

The national attention sparked by reporting on waiting times and patient deaths at the Phoenix Health Care System has resulted in a dramatic increase in the number of contacts to the OIG hotline.

In fiscal year 2014 the OIG hotline received nearly 40,000 contacts, a 45 percent increase over fiscal year 2013. We saw a similar increase in the number of inquiries from the Members of Congress, with over 200, reflecting a 38 percent increase in congressional requests. We expect that these upward trends will continue.

Recent attention to opioid prescription practices at the Tomah VAMC has generated interest in the OIG's practice of administra-

tive closures. Let me be clear that our work at Tomah was painstaking and comprehensive.

OIG physicians reviewed the clinical practice of providers to include quality assurance data and patient medical charts. We contacted the V.A. Police, the Drug Enforcement Agency, the Tomah and Milwaukee Municipal Police, to determine if there was evidence of narcotic abuse at the Tomah VAMC. OIG investigators were involved in an attempt to find appropriate or illegal behavior on the part of providers or patients.

Current and former Tomah pharmacists were interviewed. OIG staff reviewed the e-mails and other files from 17 employees at the Tomah VAMC.

At the end of a 2.5-year review we concluded that narcotic-prescribing practices of some Tomah staff were at the outer boundary of acceptable narcotic prescribing, and we were unable to find evidence that illegal activity was occurring. While the decision was made to close the review without a public report, we did, in fact, brief the Tomah and the network director who oversees Tomah, along with VHA central office personnel.

In January of this year I directed a review of administrative closures for fiscal year 2014 to determine whether any adjustments were to be made to our internal policies. We found that 42 percent of the administrative closures were not substantiated, 54 percent were closed because when we arrived, the facility had already taken sufficient action that resolved the issues, and 4 percent involved tort claims.

I also directed a review of our decision-making practices on closing reviews administratively and instituted a new policy requiring coordination of administrative closures within the immediate Office of the Inspector General, the Office of the Counselor to the Inspector General, and our Release of Information Office. This process will ensure consistency in decision-making regarding when and how public release of related documents is handled.

This week we began publishing administrative closure reports on the OIG Web site. Additional reports will be published pursuant to the Freedom of Information Act as we complete the process of reviewing and redacting sensitive information.

For fiscal year 2015 the OIG is funded at $126.4 million. The President's budget proposed $126.7 million for fiscal year 2016, a three-tenths of 1 percent increase, which will require a reduction of 10 full-time employees.

Without additional resources, we cannot meet the demands of increased congressional and other hotline contacts. It will be practically impossible to maintain our schedule for cyclical inspections of V.A. medical centers, outpatient clinics, VBA regional offices, and other national reviews.

Our investigative staff is also stretched to the breaking point by the rise in threats and assaults, fiduciary fraud, drug diversion, identity theft, and service-disabled veteran-owned small business fraud. We believe an increase of $15 million over the fiscal year 2015 enacted level will enable us to surpass our performance in terms of productivity, quality, and timeliness, and help meet the unprecedented increase in our workload.

Mr. Chairman, we appreciate the committee's continued interest and support, which has included the addition of $5 million above the President's request during the last 2 fiscal years.

This concludes our statement, and we would be happy to answer any questions you or any other Member may have.

Richard J. Griffin
Deputy Inspector General

Richard J. Griffin was appointed as Deputy Inspector General of the Department of Veterans Affairs on November 23, 2008. With the Inspector General, he directs a nationwide staff of auditors, investigators, health care inspectors, and support personnel. His office conducts independent oversight reviews to improve the economy, efficiency, and effectiveness of VA programs, and to prevent and detect criminal activity, waste, abuse, and fraud. Mr. Griffin previously served as VA Inspector General from November 1997 to June 2005.

Mr. Griffin came to VA from the Department of Housing and Urban Development Office of Inspector General where he served as a senior advisor to the Inspector General from March 2008 to November 2008, assisting him in managing all aspects of that organization's audits, inspections, investigations, congressional and public affairs, budget, and strategic planning.

Mr. Griffin served as the Assistant Secretary for the Bureau of Diplomatic Security at the Department of State where he led a global workforce of 32,000 security and law enforcement professionals from June 2005 to November 2007. His office was responsible for ensuring the safe and secure conduct of United States diplomacy across the world. He concurrently served as Director of the Office of Foreign Missions, with the rank of Ambassador, where he managed reciprocity and immunity issues for foreign diplomats in the United States.

Mr. Griffin previously served as Deputy Director at the U.S. Secret Service, where he was responsible for planning and directing all investigative, protective, and administrative programs. He began his career with the Secret Service in 1971 as an agent in the Chicago office. Subsequent positions included Assistant Special Agent in Charge of the Presidential Protective Division, Special Agent in Charge in Los Angeles, Deputy Assistant Director in the Office of Investigations, and Assistant Director for Protective Operations.

During his career, he has received a number of special achievement awards including the Senior Executive Service Presidential Rank Award of Meritorious Executive in 1994 and 2011. In 2000 and 2005, he received the Exceptional Service Award of the Department of Veterans Affairs.

In 1971, Mr. Griffin earned a bachelor's degree in economics from Xavier University in Cincinnati, Ohio, and in 1984, received a master's degree in business administration from Marymount University in Arlington, Virginia. He is a 1983 graduate of the National War College. In May 2004, he received an honorary doctorate in Humane Letters from Marymount University.

STATEMENT OF RICHARD J. GRIFFIN
DEPUTY INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 19, 2015

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG). I will focus on the OIG's recent activities related to wait times within the Veterans Health Administration (VHA) as well as other areas where we have identified the need for attention by VA and Congress. I am accompanied by John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections, Office of Healthcare Inspections, Office of Inspector General.

The OIG provides oversight over all VA programs and operations including the delivery of health care services and operations, benefits administration, financial management, and information technology and security. The surfacing of allegations in fiscal year (FY) 2014 related to wait times and poor care at the Phoenix VA Health Care System (PVAHCS) was a watershed event for VA and the OIG. Those allegations increased the scope of an ongoing healthcare inspection of the PVAHCS and generated a comprehensive audit effort to determine how the PVAHCS schedulers were managing appointments. We also launched investigations at 98 VA medical care facilities into allegations that scheduling was manipulated to make wait times for outpatient appointments appear to be shorter then the actual wait times experienced by veterans. The results of our investigative work for 44 of these sites have been referred to the VA Office of Accountability Review for whatever administrative action deemed appropriate by VA management. We have prioritized our investigative efforts to complete this work at the remaining 54 sites.

The national attention sparked by reporting on PVAHCS led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline, in the number of inquiries sent to us by Members of Congress, and by veterans and their families. In FY 2014, the OIG Hotline received almost 40,000 contacts which represents a 45 percent increase from FY 2013. Based on the number of contacts received to date, we project FY 2015 will yield a similar volume of contacts. Similarly, we saw a 38 percent increase in the number of inquiries from Members of Congress, and we expect this upward trend to continue.

Despite the tremendous number of OIG staff devoted to the Phoenix review, and the significant increases in our workload, in FY 2014, we issued 310 reports, closed 880 investigations, made 467 arrests, plus an additional 47 arrests in the Fugitive Felon

Program and information from the OIG led to another 25 arrests by other law enforcement agencies, and identified $2.3 billion in monetary benefits for a return on investment of $22 for every $1 in funding.

For FY 2015, the OIG is funded at $126,411,000. The President's Budget proposed $126,766,000 for FY 2016 which reflects a 0.3 percent increase above the 2015 enacted level. This level of funding will necessitate the equivalent of a 10 FTE reduction to cover a future pay raise and expected inflation in 2016.

VETERANS HEALTH ADMINISTRATION

VA needs to continue to rededicate itself to one of its core missions which is to deliver quality health care. The VA Secretary has taken steps to reorganize VA but much work remains. The greatest challenge facing VHA is the ability to meet the healthcare needs of an increasing and widely distributed veteran population with complex medical conditions. The passage of the *Veterans Access, Choice, and Accountability Act of 2014* to address demand creates a new set of challenges on the VA system, including paying for services, ensuring that veterans who seek care outside VA receive the appropriate care, and that medical records are updated and shared both with VA providers and outside providers.

OIG work routinely reports on clinical outcomes or performance that did not meet expectations. We routinely determine that there were opportunities by people and systems to prevent untoward outcomes. In addition to local issues at the facility, there are several organizational issues that impede the efficient and effective operation of VHA and place patients at risk of unexpected outcomes.

Since 2005, we have reported in 20 oversight reports on VA's wait time and scheduling practices. Many of these reports offered recommendations to improve access to health care services in VA. In addition, we provided testimony at 19 congressional hearing on patient wait times.

Phoenix VA Health Care System Reports

Since May 28, 2014, we have issued four reports on the Phoenix VA Health Care System (PVAHCS).[1] The initial two reports (May 2014 and August 2014) were the result of work by a multidisciplinary staff from the OIG's Office of Audits and Evaluations and Office of Healthcare Inspections. The OIG found patients at the PVAHCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them. Patients frequently encountered obstacles when patients or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while

[1] *Healthcare Inspection — Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona*, February 26, 2015; *Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona*, January 28, 2015; *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, August 26, 2014; *Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*, May 28, 2014.

traveling or temporarily living in Phoenix. The problems in Phoenix were due to a failure by management to recognize the increased demands on the facility and to request and apply the resources to address those demands either through increased staffing or increased use of non-VA fee care.

Also, senior headquarters and facility leadership were not held responsible or accountable for implementing action plans that addressed compliance with scheduling procedures. The use of inappropriate scheduling practices caused reported wait times to be unreliable. The systemic underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA and PVAHCS's senior leadership ranks and mid-level managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible.

In our first two reports, we made 24 recommendations to VA to implement immediate and substantive changes to their policies and procedures. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans. In response to our work, VA reported it took immediate action to ensure 3,400 veterans who we identified needed health care services received medical appointments. Our review identified that use of unofficial wait lists and manipulation of wait time data were pervasive practices in VA. As a result, VA reported it took immediate actions to reach out to over 266,000 veterans to get them off wait lists and into clinics, made nearly 912,000 referrals to private health care providers for needed care, and scheduled approximately 200,000 new VA appointments nationwide for veterans. These reports brought much needed accountability over serious veteran access to care issues, led to changes in the highest level of VA leadership, and enactment of the *Veterans Access, Choice, and Accountability Act of 2014*, which expanded veterans' access to care outside the VA system and included a $16 billion increase in VA's funding. As of March 2, 2015, 18 recommendations from these reports remain open.

The most recent reports issued by the OIG's Office of Heathcare Inspections were the results of information received during the work conducted at the PVAHCS during the spring and summer of 2014. Our interim report on PVAHCS's Urology Services is concerning and requires VA's immediate attention.[2] It is also indicative of the challenges that VA faces in staffing and coordinating non-VA care. After experiencing a staffing shortage within the PVAHCS Urology Department, some patients were referred to a non-VA urologist via voucher or fee basis authorization. In 23 percent of cases reviewed, we found approved authorizations for care, notations that authorizations were sent to contracted providers, and scheduled dates and times of appointment with non-VA urologists but no scanned documents verifying that patients were seen for evaluations and, if seen, what the evaluations might have revealed. This finding suggests that PVAHCS has no accurate data on the clinical status of the patients who were referred for urologic care outside of the facility. Included in this group

[2] *Interim Report – Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona*, January 28, 2015.

are also patients who may have been followed routinely by the Urology Department prior to mid-2013 but, in the midst of the staffing crisis, were lost to follow-up.

The mismanagement of outside consults is not unique to Phoenix. In August 2013, we reported on problems at the Atlanta VA Medical Center (VAMC) regarding consults for mental health care.[3] In August 2014, we reported on the improper closing of non-VA care consults at the Carl Vinson VAMC in Dublin, Georgia.[4]

Opioid Management at VA Facilities

Of increasing concern in VA and in the Nation is the use of opioids to treat chronic pain and other conditions. In May 2014, we issued a national review, *Healthcare Inspections – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy* (May 14, 2014), that described some of the issues facing patients on high dosages of opioids. In addition to this national review, we have issued nine reports detailing opioid prescription issues within VA since 2011.[5]

Opioid patients frequently have complex co-morbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications. A review of medications by a pharmacist or other health care professional can prevent harmful interactions between these medications. We found that 38.8 percent of the opioid patients received medication management or pharmacy reconciliation during FY 2012.

Increasing use of opioids has been associated with increasing rates of opioid-related serious adverse effects. We determined percentages of opioid patients with evidence of a serious adverse effect that may be reasonably expected to be related to opioid therapy for the following six serious adverse effects: (1) opioid overdose, (2) sedative overdose, (3) drug delirium, (4) drug detoxification, (5) acetaminophen overdose, and

---

[3] *Healthcare Inspection - Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia*, April 17, 2013; *Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia*, April 17, 2013.

[4] *Healthcare Inspection - Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, Georgia*, August 12, 2014.

[5] *Healthcare Inspections – Alleged Inappropriate Opioid Prescribing Practices Chillicothe VA Medical Center, Chillicothe, Ohio*, December 9, 2014; *Healthcare Inspections – Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama*, July 17, 2014; *Healthcare Inspection - Medication Management Issues in a High Risk Patient Tuscaloosa VA Medical Center, Tuscaloosa, Alabama*, June 25, 2014; *Healthcare Inspection – Quality of Care Concerns Hospice/Palliative Care Program Western New York Healthcare System, Buffalo, New York*, June 9, 2014; *Healthcare Inspections – Alleged Improper Opioid Prescription Renewal Practices San Francisco VA Medical Center, San Francisco, California*, November 7, 2013; *Healthcare Inspection – Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic*, August 21, 2012; *Healthcare Inspection – Alleged Improper Care and Prescribing Practices for a Veteran Tyler VA Primary Care Clinic, Tyler, Texas*, August 19, 2011; *Healthcare Inspection – Patient's Medication Management Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska*, August 10, 2012; *Healthcare Inspection – Prescribing Practices in the Pain Management Clinic at John D. Dingell VA Medical Center, Detroit, Michigan*, June 15, 2011.

(6) possible and confirmed suicide attempts. We found that less than 1 percent of the population experienced any one of these adverse effects during the fiscal year, except for the adverse effect of possible and confirmed suicide attempts that was evident in 2 percent of the opioid patients.

The Veterans Access, Choice, and Accountability Act of 2014
Implementation of the *Veterans Access, Choice, and Accountability Act of 2014* is a considerable challenge for VA.[6] In addition to coordinating care for patients outside the VA system, VA also has to ensure that payments are made timely and accurately and that results of medical appointments are shared between VA and non-VA providers. These issues have been problematic in the past for VA. The OIG has provided significant oversight of billing issues in the non-VA Fee Care program over the last several years.[7]

Staffing Report
The Choice Act requires the OIG for the next 5 years to report on the staffing needs of VHA. Our first report was issued on January 30, 2015, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, in which we reported that the five occupations with the largest staffing shortages were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist. The access to care issues that VA continues to face as well as the results of this review illustrate the problems that VA faces in staffing its facilities to meet the increasing demand for services. We are working with VHA to improve data quality so that future reports will identify manpower needs based upon staffing standards.

VHA's National Call Center for Homeless Veterans
The OIG conducted a review to assess the effectiveness of VHA's National Call Center for homeless veterans in helping veterans obtain needed homeless services.[8] The call center is VA's primary vehicle for communicating the availability of VA homeless programs and services to veterans and community providers. Our oversight identified serious problems in the Call Center's intake and referral processes that were seriously hampering the Call Center's effectiveness and services to homeless veterans.

---

[6] Also referred to as the Choice Act.
[7] *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, August 3, 2009; *Veterans Health Administration – Review of Outpatient Fee Payments at the VA Pacific Islands Health Care System*, March 17, 2010; *Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program*, June 8, 2010; *Audit of Non-VA Inpatient Fee Care Program*, August 18, 2010; *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System*, November 8, 2011; *Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado*, April 12, 2012; *Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations*, August 20, 2012; *Veterans Health Administration – Review of South Texas Veterans Health Care System's Management of Fee Care Funds*, January 10, 2013.
[8] *Veterans Health Administration – Audit of The National Call Center for Homeless Veterans*, December 3, 2014.

We found that 27 percent of homeless veterans who contacted the Call Center in FY 2013 could only leave messages on an answering machine because counselors were unavailable to take calls. Additionally, 16 percent could not be referred to VA medical facilities because their messages were inaudible or lacked contact information, and approximately 4 percent were not referred to VA medical facilities because the Call Center did not follow up on referrals to medical facilities.

Of the approximately 51,500 referrals made in FY 2013, the Call Center provided no feedback or improvements to VAMCs to ensure the quality of the homeless services and closed 47 percent of referrals even though the VA medical facilities had not provided the homeless veterans any support services. In total, we identified 40,500 missed opportunities where the Call Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services from VA medical facilities.

We recommended the Interim Under Secretary for Health stop the use of the answering machine, implement effective Call Center performance metrics to ensure homeless veterans receive needed services, and establish controls to ensure the proper use of Call Center special purpose funds.

VETERANS BENEFITS ADMINISTRATION

The Veterans Benefits Administration (VBA) is charged with providing compensation benefits for those injured during their service in the military. The accurate and timely delivery of these benefits has continued to be a major challenge for VA. Our oversight indicates that much work continues to be needed before VA can consistently deliver earned and needed benefits to our veterans timely and accurately. Further, VBA needs to improve its financial stewardship of taxpayer funds, data integrity and overall claims management, and focus more efforts on addressing the timeliness and accuracy associated with processing veterans' claims. The OIG's recent reviews of allegations of VA Regional Office (VARO) mismanaged operations are identifying troubling breakdowns in the processing controls for claims, data manipulation of claims information, and inadequate storage of claims.

We have reviewed two of VBA's initiatives to address the claims backlog—the initiative to address claims over 2 years old and the Quick Start Program.[9] With both we found significant areas of concern.

- *Special Initiative* - In April 2013, VBA began a Special Initiative to process all claims pending over 2 years. VBA staff were to issue provisional ratings for cases awaiting required evidence and complete these older claims within 60 days. For our review, we focused on whether (1) provisional ratings resulted in veterans receiving benefits more quickly and helped eliminate the backlog, and (2) older claims were accurately processed under the Special Initiative.

[9] *Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years*, June 14, 2014; *Audit of the Quick Start Program*, May 20, 2014.

We found that the Special Initiative rating process was less effective than VBA's existing rating process in providing benefits to veterans quickly. With the implementation of the Special Initiative, VBA instituted two changes that misrepresented its reported progress toward eliminating the backlog as well as other claims processing statistics. First, VBA normally defines claims as pending until all required actions are completed. Under this initiative, VBA considered claims to be complete upon issuance of provisional ratings, even though final decisions had not been made. VBA removed these provisionally-rated claims from the backlog while veterans were still awaiting final decisions. This made the backlog appear lower as provisional ratings were issued. Second, VBA normally measures the number of days a claim is pending from the date of claim, defined as the earliest date VA received the claim in any of its facilities. However, following receipt of additional evidence on a provisional rating, staff were to establish a new rating claim using the date of receipt of that evidence as the new date of claim. This policy change kept the newly established claims from immediately becoming part of the backlog, making the claims appear more recent than they actually were. This also made VBA's workload statistics on average days claims were pending appear even smaller. Then, once staff issued final ratings, it appeared that VBA completed these claims twice, calculating the average days to complete claims to be even lower.

We estimated VBA staff inaccurately processed 17,600 of 56,500 claims, resulting in $40.4 million in improper payments during the Special Initiative period. We recommended the Under Secretary for Benefits establish controls for all provisionally-rated claims, reflect these claims in VBA's pending workload statistics, expedite finalization of provisional ratings, and review for accuracy all claims that received provisional ratings under the Special Initiative.

- *Audit of the Quick Start Program* – The OIG evaluated the Quick Start Program to determine if VBA's timeliness and accuracy of claims processing improved between 2011 and 2013. The Quick Start Program was initiated to improve claims processing and eliminate the claims' backlog by offering service members a seamless transition from the Department of Defense (DoD) to VA. We found while there were improvements in the average days to complete the claim and the accuracy of the claim, the timeliness of processing these claims and the accuracy remains a challenge. This occurs because of insufficient oversight and training, and conflicting guidance on granting service connection for medical disabilities. We also projected that inaccurate claims processing resulted in some veterans being underpaid and others overpaid. We reported that veterans using this program experienced an average delay of 99 days in receiving benefits valued at almost $20 million in FY 2013.

Several of our national audits have raised concerns about VBA's financial stewardship including, our audit work dealing with VA benefits and military drill pay, payments under the GI Bill, the management of mail at the Eastern Area Fiduciary Hub, and our continuing work related to temporary 100 percent disability ratings. [10]

- *Concurrent VA and Military Drill Pay* – This audit determined that VBA did not timely process VA benefits offsets when drill pay was earned concurrently and projected that if VBA improved their controls, VBA could recover approximately $478 million from FY 2013 through FY 2017. In total, we identified that VBA could recover approximately $623 million in improper payments.

- *Payments Under the G.I. Bill* – We evaluated VBA's management of the Post-9/11 G.I. Bill monthly housing allowance and book stipend payments. Our review found that 92 percent of student records that we sampled experienced processing delays in the approval of their original claims, and 18 percent experienced payment processing delays in their housing allowance and book stipends. Based on these results, we estimated that 77,800 students annually experience delays in the processing of about $60.8 million in housing allowances and book stipends. We also reported that VBA's controls need to be strengthened to reduce improper payments and estimated that they could save $35 million over the next 5 years with improved controls.

- *Eastern Area Fiduciary Hub* – In response to allegations received in the OIG's Hotline, we reviewed the Eastern Area Fiduciary Hub in Indianapolis, Indiana; activities related to merit reviews; field examinations; and mail management. We found that the office had over 11,000 pending field examinations that exceeded VBA timeliness standards, failed to take appropriate action when a misuse determination was made involving fiduciary accounts, and that over 3,000 pieces of mail were not processed within its timeliness standards.

- *Temporary 100 Percent Disability Rating* – Our work in the area of temporary 100 percent ratings began when we issued an audit report in January 2011.[11] In that report, we projected that without improved management, VBA could overpay veterans $1.1 billion in the next 5 years. In our June 2014 report, we followed-up that original work, and while VBA made some progress, they did not take sufficient action to ensure that improper payments were not issued. In the 2014 report, we projected a loss of approximately $222 million to the Government if veterans were not scheduled for follow-up appointments. Both of these audits demonstrated a compelling need for improved management of temporary rating decisions to ensure disability ratings are supported with appropriate medical evidence.

---

[10] *VBA's Management of Concurrent VA and Military Drill Pay Compensation*, June 3, 2014; *Audit of Post- 9/11 G.I. Bill Monthly Housing Allowances and Book Stipend Payments*, June 11, 2014; *Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub*, May 28, 2014; *Follow-up Audit of 100 Percent Disability Evaluation*, June 6, 2014.

[11] *Audit of VBA's 100 Percent Disability Evaluations*, January 24, 2011.

In addition to conducting our cyclical inspections of VAROs, since June 2014, we have received allegations of improper mail management, mail storage, and data manipulation at 11 VAROs that necessitated a reprioritization of our work. This increase in allegations resulted in a decrease of the annual inspections in FY 2014 from the projected 20 to 10. If we continue to receive allegations about specific VARO operations, we may need to further reduce the number of planned inspections in FY 2015. The issues that we have reviewed and reported on include improper storage of claims and supporting information, data manipulation, identification of unprocessed workload, and mail mismanagement. As of March 13th, we have issued six benefits inspections reports.

OTHER AREAS OF CONCERN

VA's procurement practices and management of information technology continue to be areas of concern and challenge to VA. We have issued reports dealing with construction contracts, contracts for information technology (IT) needs, and IT security.

Construction Contracts

In FY 2014, we issued a report on VA's management of several health care center leases that found that VA's process was not effective and did not fully account for expenditures.[12] Among our recommendations was to establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities and establish central cost tracking to ensure transparency and accurate reporting on Health Care Center expenditures.

We also reviewed VHA's non-recurring maintenance program where expenditures increased from $824 million in FY 2008 to $1.8 billion in FY 2013. We reported that VHA did not have an adequate process to track how much of the over $1.8 billion in non-recurring maintenance funds medical facilities spent to address its nearly $10.7 billion identified facility maintenance backlog.

Information Technology Management

In our audit of the Office of Information and Technology's (OIT) management of the Pharmacy Reengineering program (PRE), we reported that OIT needed stronger accountability over cost, schedule, and scope.[13] We recommended the Executive in Charge and Chief Information Officer ensure all of the time used, including the time on the initial operating capability phase, to complete each remaining PRE increment is reported and monitored; ensure adequate oversight and controls, including the planning guidance, staffing, and cost and schedule tracking needed to deliver functionality on time and within budget; and establish a plan for future funding of PRE until a decision on an integrated Electronic Health Record is made. The CIO agreed and provided an acceptable corrective action plan. We will continue to assess OIT's corrective actions in the future and review the effectiveness of VA's efforts to implement other IT investments in system development and redesign.

---

[12] *Review of VA's Management of Health Care Center Leases*, October 22, 2013.
[13] *Audit of VA's Pharmacy Reengineering Software Development Project*, December 23, 2013.

Based on information received through the OIG Hotline, we conducted a review of allegations that VHA's Chief Business Office (CBO) violated appropriations law by improperly obligating a total of $96 million of medical support and compliance funds to finance the development of the Health Care Claims Processing System (HCCPS).[14] We substantiated that $92.5 million was improperly obligated, The CBO spent approximately $73.8 million and $18.7 million remains obligated. Medical support and care appropriations are only authorized for administering medical, construction, supply, and research activities.

We recommended the Interim Under Secretary for Health establish oversight mechanisms, seek the return of all medical support and compliance appropriations, de-obligate all current medical supply and compliance funds, and obtain appropriate funding for HCCPS development. We also recommended that the Interim Under Secretary determine if appropriate administrative action should be taken against senior officials in the Purchased Care organization's chain of command.

Information Technology Security

In May 2014, we published our annual assessment of VA compliance with the Federal Information Security Management Act (FISMA) and applicable National Institute of Standards and Technology guidelines.[15] We contracted with the independent accounting firm, CliftonLarsonAllen LLP, to perform this audit. We found that VA had made progress developing policies and procedures but still faced challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted, FISMA audits continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems.

Weaknesses in access and configuration management controls resulted from VA not fully implementing security control standards on all servers and network devices. VA has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, database and server platforms, and Web applications VA-wide. Further, VA has not remediated approximately 6,000 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its overall information security posture.

As a result of the FY 2013 consolidated financial statement audit, CliftonLarsonAllen LLP, concluded a material weakness still exists in VA's information security program. We recommended the Executive in Charge for Information and Technology implement comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems. We plan to issue the FY 2014 FISMA audit results shortly.

---

[14] *Report Highlights: Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System*, March 2, 2015.

[15] *VA's Federal Information Security Management Act Audit for Fiscal Year 2013*, May 29, 2014.

OIG INVESTIGATIVE WORK

From October 1, 2013, through March 6, 2015, the OIG's Office of Investigations opened 1,812 investigations and worked 630 investigations to closure, resulting in the arrest of 691 individuals for a wide variety of criminal offenses. Criminal fines, penalties, restitutions, civil judgments, and administrative recoveries exceeded $70.5 million. We additionally opened and closed another 3,000 preliminary inquiries regarding alleged crimes and/or serious misconduct.

Eligibility Fraud in Service-Disabled Veteran-Owned Small Business (SDVOSB) Program

We continue to aggressively pursue allegations of eligibility fraud involving companies and individuals taking advantage of set-aside contracting in VA's SDVOSB program. To date, our investigations have resulted in the indictment of 45 individuals and 5 companies. Defendants have been sentenced to a cumulative total of imprisonment exceeding 26 years and fines and restitution exceeding $14 million. Sixty individuals and companies deemed culpable of committing this type of fraud have been referred to VA for suspension and debarment action to exclude them from receiving future contracts.

Fiduciary Fraud

The Fiduciary program's mission is to protect VA beneficiaries who, due to injury, disease, or age, are unable to manage their VA benefits. Under the program, VA appoints a fiduciary (an individual or entity) to receive and disburse VA benefits on behalf of the beneficiary. As of July 2014, VBA reported providing fiduciary services to more than 147,000 beneficiaries in FY 2013 who received more than $2.6 billion in VA benefits. Since October 1, 2013, we have arrested 17 individuals who stole money from VA beneficiaries who were unable to handle their financial affairs. In addition to terms of imprisonment, restitution of nearly $1 million was ordered. Among them was a fiduciary in Minnesota who stole nearly $300,000 from veterans and Social Security beneficiaries entrusted to her care.

Threats and Assaults

Since October 1, 2013, we conducted more than 1,000 preliminary inquiries and full investigations relating to threats made against VA employees and facilities resulting in 44 arrests and/or involuntary commitments. Although most threat-related investigations do not result in judicial action, we take all threats against VA employees and VA property seriously. We also conducted 17 assault investigations resulting in 24 arrests, and 9 sexual assault investigations resulting in 4 arrests. These investigations involved veterans assaulting VA employees and other veterans, as well as VA employees assaulting veterans and other VA employees. In one investigation, a veteran was sentenced to 2 years' incarceration after pleading guilty to threatening to kill Atlanta, Georgia, VAMC medical staff by going to his residence to get a weapon, return, and shoot them in the head if he was not granted a 100 percent disability pension rating. The veteran left the VAMC and before he could return he became engaged in a shootout with local police at his residence after the officers responded to a domestic disturbance call.

Identity Theft, Procurement Fraud, and Improper Payments
We have recently added headquarters staff to focus our national efforts to combat identity theft, procurement fraud, and improper payments resulting from criminal conspiracy. During this time period, we arrested 16 individuals who stole veterans' personally identifiable information (PII) for a variety of criminal schemes, but primarily to facilitate Federal income tax refund fraud exceeding $6 million. In one investigation, a former VAMC clerk and a VA volunteer were sentenced to 72 months' and 48 months' respectively for exchanging VA patients' PII for money and illicit drugs.

As a result of an OIG investigation, 14 individuals were prosecuted on bribery charges, including an engineer at the East Orange, New Jersey, VAMC who was convicted of conspiring with a contractor to defraud VA of more than $6 million. In another investigation, we convicted a former VA contracting officer in Palo Alto, California, VAMC for accepting more than $100,000 in cash, vacations, and other items of value in exchange for her influence in awarding contracts. To date, this investigation has resulted in criminal charges against two other VA employees and one contractor. In a third investigation, we convicted the former Director of the Cleveland, Ohio, and Dayton, Ohio, VAMCs on 64 corruption-related charges related to the sale of confidential information about VA contracts and projects to multiple contractors; one of the contractors used the inside information to obtain an advantage in securing a contract valued at approximately $20 million.

Our 14-year proactive program to identify VA monetary payments made to deceased payees has resulted in 691 arrests and the recovery of nearly $80 million. We have recently initiated efforts to identify and thwart national criminal schemes to redirect VA benefits by defrauding the multi-agency *eBenefits* system, as well as to detect billing fraud in fee basis and overseas medical care programs. One of our investigations, resulted in the conviction of a DoD employee living in Germany for defrauding VA and the Office of Personnel Management of more than $2.2 million in medical reimbursements, which exposed considerable vulnerabilities in VA's overseas medical care program.

Drug Diversion
Since October 1, 2013, we have arrested 184 individuals who diverted and/or sold controlled and non-controlled substances from and at VA facilities. Among them were VA health care providers who stole pain medications intended for specific patients and consumed them while on-duty and delivering patient care; patients who sold their prescribed drugs to other VA patients; individuals who sold contraband drugs such as heroin at VA facilities; and employees of delivery services, including the U.S. Postal Service, who stole prescription drugs intended for VA patients. As a result of one such investigation, a Long Beach, California, VAMC pharmacist, three pharmacy technicians, and a distribution supervisor pled guilty to stealing more than 16,000 tablets of prescription medications.

Beneficiary Travel Fraud

We have worked closely with VA to identify, investigate, prosecute, and deter fraud associated with VA's beneficiary travel reimbursement program, whose expenditures approached $797 million in FY 2014. We believe our efforts with VA to enhance VA's data mining efforts and develop more effective warning posters to be placed where veterans submit claims for these beneficiary travel benefits, coupled with increased media attention resulting from DOJ press releases, have played a significant role in deterring such crime. VA reports expending nearly $43 million fewer dollars in this program in FY 2014 than in FY 2012.

OIG INITIATIVES

In FY 2015, we have initiated projects in several high priority areas—contracts for VA's Patient-Centered Community Care (PC3) initiative; allegations of mismanagement at VHA's Health Eligibility Center; oversight of VBA's fiduciary program; the interaction between the DoD and VA with regard to providing for care for victims of military sexual trauma; VA's formulary issues; and credentialing and privileging issues.

Patient-Centered Community Care

In September 2013, VA awarded Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation PC3 contracts totaling $5 billion and $4.4 billion, respectively. The expected life of the contracts is a base year plus 4 option years. VHA established the PC3 contracts to provide veterans timely access to high-quality care from a comprehensive network of non-VA community providers.

We currently have five projects that are reviewing various aspects of VA's PC3 contract and the effectiveness of its implementation. All five focus on the operational risk areas that directly affect veterans' waiting times, access to services, and continuity of care. The first review that we expect to complete is this Committee's request to determine whether VA's PC3 contracts would save $13 million in FYs 2014 as VA stated in its budget submission.

The remaining four projects are reviewing whether PC3 contracted care issues are causing delays in patient care; whether PC3 networks are providing adequate veteran access to care; whether PC3 contractors are providing VHA with timely medical documentation; and the effectiveness of PC3 contract pricing. We plan to issue all of these reports in FY 2015.

Review of Alleged Mismanagement at VHA's Health Eligibility Center

The OIG expanded an ongoing project at the Health Eligibility Center (HEC) in Atlanta, Georgia, at the request of the Chairman of the U.S. House Committee on Veterans' Affairs. Specifically, we are reviewing whether there is a backlog of applications for health benefits in a pending status; whether veterans died while their applications were in a pending status; whether HEC staff purged and deleted veterans' applications; and whether the HEC had discovered about 40,000 unprocessed applications covering a 3-year time period. A major obstacle in completing our work is the serious data integrity issues with the HEC information system. This condition has limited our ability

to determine the extent of issues being reviewed; however, we expect to publish our report in FY 2015.

VBA Fiduciary Program
We are currently working on two audits addressing the management of VBA's fiduciary program field examinations and managements of accounts when misuse had been identified. This work is important because it addresses the effectiveness of vital support service to veterans who cannot perform these services for themselves. We plan to publish reports in FY 2015.

Review of Care for Military Sexual Trauma
We are working with the DoD to obtain data so that we can examine VA medical care delivered to veterans with a history of military sexual trauma from DoD. Once a Memorandum of Agreement for data sharing is signed, we will brief Members of Congress who have expressed an interest in this topic.

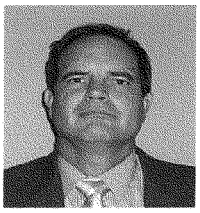
Low Volume Physicians' Professional Practice Evaluations in VHA Facilities
To ensure that physicians are both competent when hired and remain competent during the course of their employment, VHA credentials and privileges providers on a regular basis. In the credentialing process, the facility verifies the physician's education, licensure, and formal training. In the privileging process, the facility decides which procedures or services a physician can provide at their facility based on their licensure, training, and experience. Facilities are required to monitor individual physician performance over time and re-privilege them every 2 years, to make sure they maintain their competence to perform specific procedures or services. The re-privileging of specialists at facilities with small staff levels is an area of concern because re-privileging needs to be completed by staff with experience in that specialty. When a facility only has one physician in a particular specialty, they should be seeking assistance from staff outside of that facility during the re-privileging process. We expect to publish a report in FY 2015.

Review of Non-Formulary Drug Requests in VHA
Formulary management is an integral part of VA's comprehensive health care delivery process. VA National Formulary (VANF) is a listing of products (drugs and supplies) that must be available for prescription at all VA facilities, and cannot be made non-formulary by a VISN or individual medical center. The VANF is the only drug formulary authorized for use in VHA. The formulary management process must provide pharmaceutical and supply products of the highest quality and best value, while ensuring the portability and standardization of this benefit to all eligible veterans. "Non Formulary" refers to drugs or supplies that are defined as commercially available products, but are not included on the VANF. Our review will focus on the management of non-formulary drugs or supplies and the process for obtaining them. We expect to publish a report in calendar year 2015.

CONCLUSION

The issues confronting VA are issues that the OIG has long reported as serious and in need of attention at the VA Central Office, at the Veteran Integrated Service Network, and at the facility levels. The rededication by senior leadership and renewed commitment by employees to meet the expectations of veterans and the Nation is a step in the right direction. The OIG will continue to report on these issues until we see that change has occurred and that it is not just a temporary adjustment. However, the OIG's ability to continue its important mission, hinges upon having the resources necessary to accomplish President Lincoln's call "To care for him who shall have borne the battle and for his widow and his orphan."

Mr. Chairman and Members of the Subcommittee, Dr. Daigh and I will be pleased to answer any questions.



John David Daigh, Jr., M.D.
Assistant Inspector General for Healthcare Inspections

John Daigh, M.D. joined the Department of Veterans Affairs as the Associate Director of Medical Consultation in the Office of the Inspector General in January of 2002 and was appointed as the Assistant Inspector General for Healthcare Inspections in January of 2004. In this position, he is responsible for the Office of Inspector General initiatives that review the quality of health care provided to veterans in Veteran Affairs' hospitals, clinics, and nursing homes, in addition to the care provided to veterans through various health care contracts. He provides consultation to the investigation and audit sections of the Office of the Inspector General.

Prior to joining the Office of the Inspector General, he was on active duty with the U.S. Army for 27 years, retiring as a colonel in 2001. John Daigh split his military medical assignments between Walter Reed Army Medical Center in Washington, D.C. and Fitzsimons Army Medical Center in Denver, Colorado. His last medical assignment was as the Chief of Neurology at Walter Reed Army Medical Center where he supervised the delivery of medical care by the Department of Neurology, and the academic programs and training experiences of physicians and medical students who were training in neurology. Dr. Daigh is Board Certified in Child Neurology and Pediatrics. He obtained his medical degree from the University of Texas, Southwestern Medical School, in Dallas, Texas upon graduation from the United States Military Academy (class of 1974). He trained in Pediatrics and Neurology in Dallas, Texas and Denver, Colorado. Dr. Daigh is licensed to practice medicine in Maryland.

Dr. Daigh is a Certified Public Accountant who obtained his undergraduate accounting education at the University of Maryland, University College. He studied taxation at the American University in Washington, D.C. where he earned his Masters in Taxation. He is licensed as an accountant in Maryland. His last assignment while on active military duty was as the Director of Program, Budget, and Execution for the TRICARE Management Activity, the appropriation holder for the military medical appropriation. In this position, he led the effort by the military medical services' resource managers to properly budget and administer the military health care appropriation.

Dr. Daigh was born in Ft. Worth, Texas to a new lieutenant in the Army. His childhood was spent at various locations as his family moved to comply with the request of the Army. He graduated from high school in Highland Falls, New York.

Dr. Daigh is married and has two children. He and his wife reside in Maryland.

WAITING LIST SCANDAL

Mr. DENT. Thank you, Mr. Griffin.

And I will get to the Tomah issue in a moment, but I just wanted to first start with the waiting list scandal.

Your office was obviously thrust into the epicenter of the wait list scandal last year. Your testimony indicates that you have undertaken 98 audits responding to allegations of scheduling manipulation and that so far you have referred 44 audits to the department's Office of Accountability Review for administrative action. You are still working at the other 54 sites.

Should we conclude from the 44 completed audits that scheduling manipulation was endemic to all the hospitals you visited? And are the violations you identified matters of breaking the law or administrative malfeasance, and has the Department of Justice been willing to take any of these cases you have identified?

Mr. GRIFFIN. I can't tell you as I sit here if 100 percent of the facilities were manipulating wait times, but I can tell you it was certainly widespread throughout the system. We have presented these cases to the U.S. Attorney's Office; 33 of the cases that were presented have been declined for prosecution, with the suggestion that they be referred to the department for administrative action, which is, of course, what we would do anyway.

We have eight that are still pending with DOJ and, of course, you know, each individual U.S. Attorney's Office has their own caseload and their own decision matrix as to what they accept for prosecution and what they don't, but certainly any time that we had evidence of criminality we presented these cases.

Mr. DENT. There are conflicting media reports in the wake of President Obama's visit to the Phoenix hospital. One of the whistleblowers said that progress was being made and that terrific strides had been made in on-time appointments; another one of the whistleblowers dismissed any notion of progress and said that the V.A. was still gaming the system of appointment delays.

What conclusions have you made about the pace of the progress from your most recent audits?

Mr. GRIFFIN. We issued an interim report on Phoenix urology issues within the last 30 days. It is something that came to our attention when we were in Phoenix initially. We had to set it aside because we wanted to get the waiting times report out the door.

We found some 750 veterans that were waiting for urology care for extended periods of time that appeared to be unaccounted for in the system.

So there are issues. It took a long time for the system, systemwide, to get into the state that we found it in, and I think it is going to take a long time to get it all straightened out.

OMI AND OIG DIFFERENCES

Mr. DENT. And I would like to also just follow up on the last comment on Phoenix. After the Phoenix wait list scandal the V.A. took steps to reorganize and strengthen the Veterans Health Administration's Office of Medical Inspector, OMI, including creating an audit capacity for that office.

What does the OMI do that is different from the OIG? Do the two groups often have the same cases?

Mr. GRIFFIN. We have a statutory requirement to oversee the work of the OMI, so we would never do duplicate work because we would tell them—if they were going to initiate something we already were working. They are in regular contact with Dr. Daigh's office. It is not unlike our relationship with GAO. If we are doing an audit on a certain subject it would make no sense, so——

Mr. DENT. So it is not redundant?

Mr. GRIFFIN. Previously, as a medical inspector, they were the under secretary's early warning mechanism. If there was something that he wanted them to go look at before it became a national crisis, he could dispatch his medical inspectors prior to it coming to anybody's attention, just based on one of his directors hopefully saying, "I think we need someone to come out and take a look at this." The audit aspect is a new twist for them.

TOMAH ISSUE

Mr. DENT. I would like to quickly move to the Tomah issue, if we could. Your office has obviously been investigating the Tomah, Wisconsin V.A. hospital case of over-prescription of opioid drugs, which gained a lot of national attention. And your office has faced some criticism for concluding that doctors' prescription policies were within the scope of practice.

Last week the department released its preliminary clinical findings on Tomah and reported that the V.A. team found unsafe clinical practices at Tomah in such areas as pain management and psychiatric care. The department also noted that the Tomah hospital had double the national average in the simultaneous use of benzodiazepines and opioids, a practice which is discouraged by official V.A. policy. These findings seem to indicate a significant problem.

I guess the question is, why did the I.G. conclude that prescribing behavior was in the scope of practice, or you said they perhaps pushed an outer boundary?

And then finally your office also had received some negative publicity recently. It was a USA Today story on March the 8th related to the Tomah case because you administratively closed the case without publicly releasing the report and response.

You talked about it in your testimony, but on Tuesday you established a new policy that administrative closures would be decided centrally. Out of the 140 reports that have not been released, you have released five with sensitive information redacted and your staff is reviewing the other 135.

NEW CENTRAL POLICY ON RELEASING REPORTS

Can you tell us what the new central policy would be on releasing those reports? Are reports, even those with confidential information and unsubstantiated allegations, being released with appropriate redaction? Is there no standard policy government-wide for I.G.s to follow about the circumstances in which I.G.s must release the reports from their investigations and their audits?

I kind of gave you three issues there: Tomah, the most recent issue of the disclosure of the reports, and a standard for I.G.s generally.

Mr. GRIFFIN. Regarding the recent publication by Dr. Clancy, our work there covered a point in time from 2011 to 2013, and during that time we looked at the specific patients and the specific medical records that were in play at that time. We are back in Tomah now looking at some of the new allegations involving new patients, and we have another investigation ongoing there. For it to be misunderstood that a current review somehow has application to the work that Dr. Daigh's team did isn't exactly the way it should be described.

Your second question on administrative closures.

I can tell you that other I.G.s do administrative closures and that based on the numbers that I mentioned to you—we have 40,000 hotline requests, most of them with multiple issues they want us to look at. If we start looking at something and we are 10 percent into the review and we realize this is a dry well, it would make no sense for us to use our limited resources to pursue something when we have been convinced early on that it is either unsubstantiated or because perhaps the whistleblower or the person who raised the issue raised it through the chain of command—sometimes that happens, too—and it was taken to heart locally and fixes were put in place prior to our team even getting there.

For us to continue to do work and issue an extensive report with the additional requirements on our personnel and cost and efficiency would be a poor utilization of our resources. In the past we administratively closed such reviews.

Frankly, we are doing these now because of some misunderstanding as to whether we were hiding something. Anybody that reads these as they come out—and I think we have got 13 out this week—will see that if you were in our position you would make the same decision.

Mr. DENT. Thank you, and I would like to yield this time to our distinguished ranking member, Mr. Bishop?

Mr. BISHOP. Thank you, Mr. Chairman.

Ms. Lee has got some exigencies, and so I am going to, if the chair would allow me to yield to Ms. Lee and let her go ahead of me out of turn?

Ms. LEE. Thank you very much. I want to thank the gentleman for yielding.

UNPROCESSED INFORMAL CLAIMS

We have the Budget Committee coming up, and I really appreciate being able to ask you these questions.

So thank you, Mr. Bishop, very much.

Good morning. Good to see you.

And first, let me just thank you for responding to report language that this committee placed—I think it was the year before last with regard to the Oakland Regional Office. We indicated that there had been 13,000—over 13,000 unprocessed informal claims, and Under Secretary Hickey, in her testimony, indicated that these were actually duplicate claims, but that that still was unacceptable.

There was some recommendations based on the report that you gave us that we presented back to you that I believe it was Ms. Boor—Julianna Boor—worked with us on. And let me just—there are three recommendations, and I wanted to get a sense of what you think needs to happen next.

We recommended that the Oakland V.A. Regional Office director complete and take appropriate action on the remaining, I think it was 537 informal claims; secondly, that the Oakland regional director implement a plan to provide training to staff on proper procedures for a process in informal claims and assess the effectiveness of the training; thirdly, that the Oakland V.A. Regional Office director implement a plan to ensure oversight of those staff assigned to process the informal claims.

I think you know that Oakland has been one of the worst, and you have made a lot of progress, so I want to thank you for that. But also, getting to 2015 goal of no disability claim being more than 125 days old, I can't for the life of me figure out how that is going to happen, given what is taking place and what has taken place in processing in Oakland.

So are you going to continue to investigate, continue to monitor? How do we make sure that we reach the goal of 2015?

Mr. GRIFFIN. I think that was a stretch goal when it was articulated. I think there has been extreme emphasis placed on processing claims, and a lot of other collateral duties that VBA has have fallen by the wayside.

And we were in a meeting about this subject and the answer was, "We don't have enough staff."

And I said, "Well, we are making millions of dollars in improper payments that could be used to hire staff and get adequately staffed so things can be done right." I came away from the meeting believing that there was going to be a request for that.

They are up against it, there is no question. The increase in demand since 9/11 for the post-9/11 veterans has them and VHA drowning in demand. And as you know, they have been under a fair amount of pressure to try and get this backlog cleaned up.

I would applaud their effort, but I am afraid that in part what has happened is some of the backlog is getting moved around and not getting resolved. Some of it is going to——

Ms. LEE. That is what we are seeing there.

Mr. GRIFFIN [continuing]. It is going to wind up at the Board of Veterans Appeals or it is going to be temporarily taken off the table, which was part of another initiative they have on the 2-year-old claims, but then it has to come back to be finalized later on.

So there are a lot of issues. You are right, Oakland was not one of their high achievers.

Ms. LEE. One of the lowest——

Mr. GRIFFIN. Exactly. But thanks to some funding we got through this committee a few years ago, we created that inspection program. And we get to every regional office once every 3 years so we can look at the more difficult claims and see if they are doing them correctly or not, or are they making improper payments, and so on.

So we know they had problems with Oakland. With the 13,000 you alluded to, as you know, they didn't even have sufficient

records as to be able to go back after the fact and confirm that they fixed those 13,000, so more work needs to be done, no question.

Ms. LEE. Okay. So is there a plan to go back to determine if those 13,000 were fixed? And then do you think that the goal of the claims being no more than 125 days old by 2015 can be attained or not?

Mr. GRIFFIN. I don't believe that will happen, but we all hope it could happen. But, like I said, I think it is a stretch goal.

Ms. LEE. Okay.

Well, Mr. Chairman, I would hope we could figure out a way to help make sure that goal is achievable since that is the goal, because these veterans deserve better that what is taking place now.

So thank you very much.

Mr. GRIFFIN. Thank you.

Mr. DENT. Thank you, Ms. Lee, and thank you for your service on the Budget Committee. I know you are a little busy today. Hope you got a little sleep.

At this time I would like to recognize Mr. Jolly for 5 minutes?

Mr. JOLLY. Thank you, Mr. Chairman.

And, Mr. Griffin, Dr. Daigh, thank you for being here.

We are coming off one of the worst scandals of the last few years within the V.A., where your office uncovered widespread abuse, manipulation of wait lists. You are the independent inspector.

This is the Appropriations Committee, though, not the Authorizing Committee. The President's budget proposes overall an increase of around 7 percent for the department, but for your department and the inspector general's department only 0.3 percent.

Your testimony says that you will have to reduce your personnel by 10 full-time employees under the President's proposed budget. Is that correct?

Mr. GRIFFIN. Yes, that is correct.

Mr. JOLLY. Last year you issued 310 reports, 888—or 880 investigations, 70-something arrests, recovered $2.3 billion. You were responsible for, frankly, uncovering some of the greatest concerns of the American people. And the President's budget proposal requires you to cut staff if enacted at this level. Is that correct?

Mr. GRIFFIN. That is correct.

Mr. JOLLY. In your oral testimony you reference if it was up to you you would be requesting an additional $15 million?

Mr. GRIFFIN. That is correct.

Mr. JOLLY. And what would that enable you to do? If at $126 million you are laying off 10 people, then at $141 what does that do for your operations?

Mr. GRIFFIN. Thank you.

We have got a 45 percent increase in hotlines. We have got an intake unit that processes those. But when there are serious violations that need to be either investigated or need a medical review by Dr. Daigh's staff or need an audit, the intake unit farms those out to the people that hit the street and do the actual work.

So what we would do is we would hire 75 additional personnel. Some of them would be in the intake unit, but some of them would work for Dr. Daigh, some would work in our criminal investigative unit, and some in the audit staff.

It would also allow us to not have to lose the 10 that you have already described.

Mr. JOLLY. And I would point this out to the committee. You know, I asked the secretary when he appeared before us what the President's budget proposal included for OIG, and I am not sure we got a clear answer that day, and I am not sure if it was obfuscation or perhaps he just didn't know.

CHOICE ACT

Is there an issue related to anything in the Choice Act? In past testimony, as I have seen over the past several weeks from the department, both on the Hill and publicly, there has been reference to the fact that perhaps your office did receive additional money sometime towards the end of last year that justifies this increase?

Mr. JOLLY. Justifies this lack of increase.

Mr. GRIFFIN. Thanks to this committee, we have received $5 million above the President's budget the last 2 years. The way the omnibus worked out last year, it was like ships passing in the night as far as the pass-back from OMB and the appropriation for 2015 occurring.

I believe that somebody saw that $5 million and concluded that, well, they already got their $5 million in 2015. But we used that $5 million to add staff to try and put our finger in the dike to stay afloat here. And based on the growth in demands, 45 percent growth, we already had to stop doing some of the cyclical reviews that we think are very important so we are not just showing up at hospitals when somebody pulls the fire alarm. You need to have a routine inspection process.

So there was a memo that came out from the Office of Management saying that there may be either a supplemental or—a reapportionment of some of the Choice Act money. Now, my reading of what the reaction has been to that idea suggests that that wasn't going to happen, but I felt compelled, if there was going to be a supplemental, based on us having to lose people, to make a serious and sincere request for additional staffing because we are going under.

Mr. JOLLY. So to be very clear, your position is that nothing that has occurred, from the omnibus to the Choice Act, any additional resources, there is nothing that has alleviated your need for additional money? This would be a real cut.

Mr. GRIFFIN. Absolutely.

Mr. JOLLY. If this President's budget is enacted at this level, this is a real cut of 10 employees to your office?

Mr. GRIFFIN. That is right. And we could use twice as much as that, but I don't want to be greedy. I am serious. There are other I.G.s that have 1,600 FTE and we have 650.

Mr. JOLLY. Thank you.

Mr. GRIFFIN. And we are the second-largest agency in the government.

Mr. JOLLY. Thank you very much.

Mr. Chairman, thank you.

Mr. DENT. Thank you.

I would like to, at this time recognize the distinguished ranking member, Mr. Bishop?

Mr. BISHOP. Thank you very much, Mr. Chairman.

CLAIMS BACKLOG

Let me go back to your budget document for a moment to try to follow up on an earlier statement that you made about the backlog. I think an OIG review found that the VBA's 2013 special initiative to expeditiously complete disability claims pending more than 2 years was not effective, and the initiatives allow use of additional ratings to process claims while awaiting receipt of requested supporting evidence was less effective in quickly providing benefits to veterans than were the existing rating procedures.

And you said although the complete provisional claims still required a subsequent final rating decision, they were omitted from the VBA's inventory of pending cases, understating VBA's total workload and its progress in eliminating the claims backlog. So basically, what I would like to get clarification on is whether or not when you take—when you eliminated the pending cases, did that increase the—did that distort the number of claims that were still unresolved and still pending?

Mr. GRIFFIN. Yes, it did. I mean, they took those provisional ratings off the table even when there might have been one or two of the several claims that had been filed that had not yet been completed, and they weren't included in the count.

BUDGET REQUEST

Mr. BISHOP. Which is really troubling to us, because, you know, we are really, really struggling to get a handle and to hold the agency accountable on the numbers. It just seems like the numbers are ambulatory, they just move all over the place.

And we have to have some real metrics so that we can track and we can hold the agency accountable so we can exercise our oversight duties.

Let me ask you something about your budget request now. You mentioned that the return on investment was five-to-one, I think, in your testimony, in terms of recovery.

The budget document seemed to suggest it was three-to-one, so that was—that kind of jumped out at me. But I find it interesting that the funding level is flat, because you actually do provide a return on investment of significantly more than has to be expended.

Can you explain the different ways that the money is recovered and how it should be invested back into V.A.? And if it were reinvested and you are generating that kind of return, why is it that you are not able to utilize that for additional FTEs in order to carry out your responsibilities?

Because, I mean, you are definitely a great asset to the taxpayer and to the agency. You are conserving resources and recovering resources.

Mr. GRIFFIN. Thank you, Mr. Bishop. I don't know where the three-to-one number comes from. Is that in the department's documents?

Mr. BISHOP. Yes. It is in the budget——

Mr. GRIFFIN. In fiscal year 2014 our return on investment, which is a number that all I.Gs use, was 22-to-1, and that number reflects monetary benefits, money that could have been put to better use.

It is mostly money that is identified in our audits that was either improperly spent or wasted.

The recoveries result from our——

Mr. BISHOP. I think it was the recoveries that were three-to-one.

Mr. GRIFFIN. Recoveries for the last 5 years were five-to-one, and that was on criminal cases, that is when there is a quitam filed and the government recovers monies that were wrongfully obtained by private sector contractors.

Now, some of that money, to the extent that we can demonstrate that V.A. procured a certain dollar value in drugs that were wrongly identified or were off-market labeling or what have you, V.A., once we can demonstrate through our work, "This is the amount of this drug V.A. purchased," then V.A. gets their share of the penalty money.

A lot of our fines and recoveries are in criminal cases. That money goes to the U.S. government—mostly to the U.S. Treasury, sometimes to asset forfeiture funds. But at the end of the day, it is all money returned to the same U.S. government on behalf of the taxpayers.

Mr. BISHOP. I guess my question is you are struggling for a lack of resources. You don't have enough FTEs. You are generating significant recoveries.

Do you have the flexibility, or does the Secretary have the flexibility, to utilize some of these recovery resources to supplement your FTEs, or do you need to come to us for additional authorities to do that?

Mr. GRIFFIN. I think that due to the independence of the I.Gs, you don't want to give the impression that we are beholden to the secretary to provide our funds. So that is why there is a separate line item in the budget. And when we don't get what we request, there is a narrative portion that we are supposed to tell the Congress, "This is how much we asked for and this is how much we were given."

Mr. BISHOP. So from the recoveries, though, does it come back to you or does it go back to the department?

Mr. GRIFFIN. No. No. It is for the good of the whole, but not to the I.G.

Mr. BISHOP. The whole department of the——

Mr. GRIFFIN. No. Some goes to V.A., some goes to the Treasury Department.

Mr. BISHOP. Thank you, Mr. Chairman.

Mr. DENT. Thanks.

Before I recognize Mr. Rooney I just want to say we are in votes. I think there are about 9 minutes left in the vote.

IDENTITY THEFT

We will have Mr. Rooney proceed and then when he is finished we will recess briefly. It is only two votes, so we will vote on the two then come right back.

So with that, I would like to recognize Mr. Rooney, for 5 minutes?

Mr. ROONEY. Thank you, Mr. Chairman.

My question is pretty brief and kind of specific to Florida, but I think it might reflect a larger issue which deals with patients at

V.A.s and identity theft. We had an issue down in Tampa recently, at the James Haley V.A. Hospital where this guy, Willie Streater, was a contractor, and he was in charge of shredding some documents.

Well, he didn't shred them, he sold them and the people that bought them, I guess, had filed fraudulent tax claims and got over $1 million for that. But it is not just that, it is benefits, it is being able to open lines of credit, health care fraud, all the things that we know are associated with identity theft.

And so I guess my questions are, why do we still use Social Security numbers with regard to patients at the V.A.? Number two, would electronic records help this issue? And finally, why do we outsource with the V.A. the way that we do, especially when there is opportunity for people with felony criminal records to be, you know, employed by our taxpayer dollars?

Mr. GRIFFIN. Identity theft is a huge problem. In the last 3 or 4 years it has been a growing area for our criminal investigative staff.

We have sent alerts to the department about the seriousness of this issue, and in the case that you referred to, how easy it is for somebody to gain access to a sufficient amount of information to be able to file a fraudulent tax return.

Frankly, Florida, unfortunately, is one of the leading areas where people have really made a career out of identity theft and the tax business. We have participated in task forces with the IRS and others to try to combat this. And as I said, we tried to alert the department on how critical it is that they guard this personal identity information.

Certainly if it is electronic you won't have to worry about somebody getting access in the case you referred to for shredding purposes, but it doesn't preclude somebody who has access to that electronic data to also do things with it, because each account that you can provide the person with on the outside has got a dollar value that would be shocking, and it is a really serious problem.

And then when the actual veteran tries to apply for his benefits the IRS says, "Well, no. You already got your refund."

"Well, no I didn't," and that can take a long time for all of that to get resolved.

Mr. ROONEY. What are your thoughts on the whole Social Security number issue, as opposed to using some other kind of identifying——

Mr. GRIFFIN. I think it would be a good idea not to use them. When we have to use them in order to identify medical records for our work, typically we will just get the last four digits of the Social Security number along with the name and we feel confident that we have got the right person and the right record.

But clearly the Social Security number is one of the key numbers that the identity theft people like to get.

Mr. ROONEY. Thank you, Mr. Chairman. Yield back.

Mr. DENT. Mrs. Roby, I was going to suggest maybe we go vote now, unless you want—do you have quick questions? Maybe we can do them quickly, or we can vote and come back.

Let's go ahead. I recognize you for 5 minutes. Then we can run downstairs——

Mrs. ROBY. Thank you for being here today. Certainly timely.

I brought a visual aid—the front page of the Montgomery Advertiser—telling the story two individuals who were whistleblowers at the Central Alabama V.A.

These two individuals couldn't take it anymore. They had to come forward. We protected their identities.

If it weren't for these two individuals, we would not know even a fraction of what we know of the gross malfeasance that has been taking place at Central Alabama V.A.

For those of you in the room that aren't familiar, everything from thousands of unread x-rays to a V.A. employee taking a veteran to a crack house. My office would not have been able to expose this culture and what is happening to our veterans in Alabama but for these courageous individuals who have stepped forward knowing that—in that particular environment—retaliation is a very real thing. Because of their frustration they finally exposed themselves because of what has been happening to our veterans.

There was a second report today—news report today that demonstrates that this is happening all over the country with V.A. employees who consider themselves whistleblowers, that they, too, are being retaliated against. There are 120 active investigations into allegations of retaliation at the V.A., and so I would want you, as you are here to defend your budget request, to—this is my opportunity to hold you accountable as to what you are doing as it relates to these very problematic and disturbing instances where at the end of the day the people who are suffering the most are our veterans.

And if we can't get it right by them in this country, I am not really sure what we can get right. So I would just ask you today to address this—why this is happening and why these individuals are not being protected properly.

Mr. GRIFFIN. I agree with you that our veterans deserve the best. I mentioned in my oral testimony that our contacts with our hotline are up 45 percent. We received 13,000 more contacts last year than the previous year.

We are very pleased to hear from whistleblowers. Dr. Daigh's team has been doing work down in Central Alabama. Our criminal investigative team continues to have open work in Central Alabama.

I don't know how much Dr. Daigh can talk about the specifics of what he is looking at down there, but we are responding to these things and we do take our job very seriously. And it is a tsunami of work, and we are trying to get through it as quickly as we can.

David, I don't know if there is anything you can——

Dr. DAIGH. No, I would be glad to comment.

I think that without whistleblowers government can't function correctly, so we are absolutely on the same page there. And I think that we need a mechanism for whistleblowers to come forward to lay out their allegations in as clear a fashion as possible. And then we need to be able to go look at those allegations as factually as we can, so that we have clear allegations and we have clear facts to either support or refute them.

And I think sometimes—and then we need a management at V.A. that, when presented with facts, will aggressively respond.

Mrs. ROBY. Can I interrupt you for a second? It would be great if we could package it up that nicely.

Dr. DAIGH. Right.

Mrs. ROBY. But the way that this happened is the director at CAVHCS lied to me and then I went seeking information. And these two courageous individuals told me the truth, and now they have been subject to an investigation for telling their member of Congress the truth.

So it wasn't like they came forward and said, "I would like to sit down and talk to somebody about what is going on at Central Alabama." They read a news article where the director there lied to me and couldn't sit back and just take it.

And so I hear what you are saying. It would be great if it was that simple, but it is not.

Dr. DAIGH. So in real life what happens—when we get allegations and we think that people in V.A. are lying, that management is not doing what they are supposed to be doing or not handling things correctly, then I walk down the hall and I talk to the head of investigations. And then the criminal investigation unit will go and address those issues, to the extent to determine whether we can put forward or collect the data required to make the case we need to make.

So we are not shy about switching quickly between an allegation in my office, an allegation that would best be handled by audit, or an allegation that would best be handled by the investigators. That happens all the time.

Typically, what happens if the investigators start down the road and there is some health care aspect to it then they are the leaders. I append either a physician or a nurse or social worker, depending on what is required to support their understanding of the data, and often reading the medical chart or interpreting some of the hospital data requires someone who does that for a living. And we work together as a team.

Mrs. ROBY. I am making my chairman nervous because the red light is flashing and the time has run out on our votes, but I just want a real commitment from you guys that you are committed to ensuring that these individuals, not just at Central Alabama but all over the country, that we take this very seriously and do all that we can through your office and others to ensure that this is not being covered up, that these individuals are recognized for their courage.

Mr. GRIFFIN. Could I just say that we do work very closely with the Office of Special Counsel that has statutory authority for whistleblowers, and I believe the director is gone, isn't he?

Mrs. ROBY. Yes, he is.

Thank you.

Sorry, Mr. Chairman.

Mr. DENT. No. They were important questions.

With zero on the clock 217 members have not yet voted, so what we will do is we will recess this meeting to the call of the chair, but I suspect we will just be back within 10 minutes, and respectful of your time, as well.

So thank you. This meeting is in recess to the call of the chair.

[Recess.]

Mr. DENT. We would like to bring to order this recessed meeting of the Subcommittee on Military Construction and V.A. We are going to move into our second round of questions right now.

STANDARDIZED AUDIT REPORTS

And I know we have to be respectful of your time, Mr. Griffin, but I just wanted to start off with Tomah, once again, and one question I asked didn't get a chance to answer. Is there no standard policy for a government—for government-wide—a standard wide policy for I.G.s to follow about the circumstances in which I.G.s must release the reports from their investigations and audits?

Mr. GRIFFIN. I believe it is pretty standardized on audit reports. Our audit reports get sent to the Hill and sent to the department at the same time, simultaneously, electronically.

If we have a restricted report, which means that there would be Privacy Act issues in the report, we post the title of the report, and if we get three requests from the public for that report we will then redact it and post the redacted version on our Web site. Other IGs do administrative closures just like we do, and it is a question of if it is a dry well, let's not waste our resources on it.

Mr. DENT. Got it.

I would like to now move on to the ongoing I.G. review at the Philadelphia Regional Office. We understand that your office has been doing a review during the past 6 months at the Philadelphia Regional Office and that so many allegations have been raised by office employees that you won't be able to investigate each allegation individually. Press reports indicate that the concerns being raised include mismanagement, retaliation, wasted government resources, and lack of accountability for certain managers.

I realize the report is not yet completed, but can you give us a sense of the scope of the problems in Philly, and how does that office rank relative to other regional offices? Are these problems that you see throughout the country? Is Philadelphia responding to the allegations with staff changes and procedural fixes?

Mr. GRIFFIN. They have put new leadership in Philadelphia. Frankly, we completed our draft report within the past week on Philadelphia. It was a project that just kept growing. Every time we went back there, more issues were put on our plate.

If you had a checklist of possible problem areas in different locations in VBA regional offices, you could have checked just about every one of them that came to our attention in Philly as far as misplaced mail, unprocessed claims. There were issues in the Veterans Service Center, they have got an insurance center up there, they have got two call centers. We had issues in all of those locations.

So it is a major project to get it back on track where it needs to be. I am sure we will have many, many recommendations in the report.

Typically, we ask for a response from the department within 2 weeks on a report like that so, you know, it should be out soon, I guess that is the principal message here.

And as far as how it might compare to other facilities, it is very bad. And there are a number of whistleblowers involved there, there are a number of accusations against management there, and that is why it has taken several months to try and get through it all.

Mr. DENT. Thank you.

I would like to quickly move over to the contract review of the Denver hospital. The inspector general has an Office of Contract Review. Does this office have a regular role in reviewing V.A. construction documents, and has that office been involved in the controversy about the contract for the Denver V.A. Hospital?

Has your office done programmatic reviews of the Denver construction project during its long history? And if so, what systematic problems has the Denver experience revealed about the V.A. construction process?

And just a point of clarification for the members, I think you should all be aware by now, but the total cost, according to Sloan Gibson, over the Denver V.A. Hospital is at $1.73 billion, and that is leaving an unfunded amount of about $830 million, which is just eye-popping, and I know the authorizers are extremely upset about this.

But it is a very serious matter and we are watching this issue very, very closely, as—from the appropriations side because of this colossal problem that, you know, has been dumped on our lap and we are being asked to resolve.

Mr. GRIFFIN. I would share with you that our audit staff had received a congressional request over a year ago to look at Denver. They started scoping the project and doing some preliminary work and then we discovered that a law suit had been filed in court by the contractor over payment issues.

It is similar to tort claims being filed by family members who think that their loved one got improper medical care in a V.A. facility. Once a tort claim gets filed it becomes a matter for the Justice Department and the legal system to make the call on whether or not the tort claim is righteous, which would cause us to shut down a review of our health care staff on the same subject, because at that point it is in the courts.

We are capable of doing a review of hospital construction. We are going to launch a review. I had a request the other day from Chairman Miller of House Veterans Affairs on the same subject.

Most of the problems seem to be when you get into change orders and lack of oversight as the project is rolling out. And something else we want to look at, the previous secretary had created a V.A. Construction Review Council a couple years ago, which apparently didn't succeed in Denver. But we want to look and see what has that Construction Review Council done, and what is their charter, and does it have the right expertise in engineering and construction and what have you to do what they were set out to do?

Personally in V.A. they have got three levels of hospitals. There are large ones that have the most sophisticated staff and can handle the most difficult procedures; there are medium-sized; and then there are small ones that are the least complex.

Most of the hospitals are very old, but when you successfully build one somewhere and you decide we need one in Orlando, or

we need one in Aurora, Colorado, or we need one in New Orleans, which are where we have activities right now, and you have got the plans for one that came in on time and on budget, let's not reinvent the wheel if it is a similar area that you are trying to service.

So we are going to look into that. It won't help any with the end game on the cost in Denver, but we want to find out why it happened.

Mr. DENT. Well, thank you. We want you to stay on top of that because this project at $1.73 billion is more than five times the facility's original estimate of $328 million. I have never seen a construction disaster of this proportion.

OFFICE OF CONTRACT REVIEW

I know the ranking member has concerns as well. And so with that, I would like to recognize the ranking member for 5 minutes.

Mr. BISHOP. Thank you very much.

I know that your office has a role of counsel, and I.G. has a contract compliance role. Is that a before-the-fact or only an after-the-fact role? Does that particular counselor in your office actually oversee the negotiation of the contract to make sure the parameters are appropriate, or is it only an after-action review at the end of the day?

I am concerned about that, to find out whether or not and to what extent your office knew about what was happening in Denver and how early it was known? I understand that this is under investigation and may be involved in litigation, and there may be some limits of what you can and can't say. But from the procedural perspective and our oversight, I would like to have some idea of how early your agency or your counsel was able to get involved in these kinds of things, because as I understand it, this contract was very unusual in that they were—they said for X number of dollars this contractor agreed to build to whatever specifications that V.A. wanted.

And apparently that was fine until the change orders started to come in. I am trying to understand how there was such a tremendous gap, why it took so long for somebody to recognize that the expected expenditures and the ultimate needs were going to be—there was going to be such a big gap.

Mr. GRIFFIN. My Counselor's group is the Office of Contract Review. You asked about that group and their responsibilities.

Our audit staff was the group that was going to look at Denver until the case wound up in court. We were not involved in the planning. That is a program function of the department.

The Office of Contract Review does pre-award audits when things are going to be placed on the federal supply schedule. The government, being the huge purchaser that it is, is supposed to get most-favored-customer pricing.

When somebody wants to sell the government aspirin or whatever the higher-cost drug might be, we want to make sure that V.A. is getting a competitive price. So they will do a pre-award to make sure that the contracting officer, who actually works for V.A. is getting advice from our staff and make sure that they take that advice, and ask the right questions, and get the best price.

On the other end, there is a post-award review, where if the vendor tells us or tells V.A., "We will sell this pill for a dollar apiece to you because you are the V.A. and you are a big buyer," and we find out later on they are selling it to Walmart for less money——

Mr. BISHOP. I am particularly interested in this construction, though.

Mr. GRIFFIN. We are going to look at that in the future. We were not involved in the planning of that facility and when we tried to initiate a review it was already in court. We will be looking at it in the future.

Mr. BISHOP. You couldn't look at it if it is in court?

Mr. GRIFFIN. The judge would decide.

Mr. BISHOP. I understand the judge would decide, but I am saying if it is in court, but you still should have the opportunity to be able to review the documents and the status of the case and have access to the court records, shouldn't you?

Mr. GRIFFIN. Well, we can get access and we will, but while it is being adjudicated in court our decision wouldn't trump the judge's decision.

Mr. BISHOP. I understand that, but I am just saying for purposes of planning and for purposes of understanding what took place, and to be able to intercede at the earliest possible moment to stop it from reoccurring in another instance—in another similar instance—it seems to me that the sooner you can get access to that information, whether it is in court or under investigation, whatever, the better it will be for the department.

Mr. GRIFFIN. I don't disagree. Unfortunately, this is not an isolated incident, as you know.

Mr. DENT. I thank the ranking member.

At this time I would like to recognize Mr. Joyce for 5 minutes.

Mr. JOYCE. I thank you, Mr. Chairman.

I thank you both for being here.

I would like to follow up on the ranking member's comments, though, I think it would be critically important to have some understanding of what took place there so that you can advise and counsel that it doesn't occur again in the initial startups of any of these buildings or things that you have going up within the Department of Veterans Affairs. And I don't take it lightly, because I spent 25 years as a D.A. before I got here, so it is one of those things where I really view your position as the most important at the V.A. to make sure these types of things don't happen.

The things that happened in the V.A.—I want to go back to—and I understand the chairman may have asked some of these questions before, and unfortunately I am on three committees and all three had hearings this morning, so I apologize if I am touching into something you already went on. But I noticed that you launched 98 other investigations into manipulations at the fallout from the Phoenix center, and that your testimony notes 44 of those have been referred to the V.A. Office of Accountability Review to address the management issues.

The other 54 sites are still under investigation. Could you share with this committee what type of conduct or mismanagement led to the 44 referrals to the V.A. Office of Accountability Review so far?

Mr. GRIFFIN. There has been a range of different methodologies involved in creating fictitious access time lists, et cetera, and some of them were potentially criminal, some of them didn't rise to the level, in the view of the U.S. Attorney's Office, to be prosecuted as criminal, and when that happens we turn them over to the Office of Accountability Review.

Mr. JOYCE. Why not the local authorities? A theft is a theft.

Mr. GRIFFIN. Well, you have to prove criminal intent in every instance, and in some instances there were schedulers who would take a call, veteran says, "I need an appointment because I have got this issue or that issue," scheduler would book it, the next available appointment that they had open at that facility, and if it was 120 days from now they would say to the veteran, "Well, Mr. Veteran, can you come in on July 15th? That is our next available appointment."

So you are given an option of one date 120 days from now. You trust that that is the first available date so you say, "Well, yes, I guess I will take it."

Well, when that gets scored as your desired date, that is not really what you wanted. You would like to come in tomorrow, but when it gets scored that way, now you are down in the lowest level of the appointment chain, and for some of the schedulers they didn't know any different. They thought, "Well, this is the next appointment I have. I can't create something out of nothing. If we don't have the staff here to get this veteran in sooner,"—some didn't realize it was wrong because it was the only thing they ever knew.

They didn't realize the bigger picture that if the Congress was not aware of the existence of these waiting times and the demand, which has been recognized now—I know Mr. Jolly co-sponsored one of the bills on this—you wouldn't have got that $16 billion in the pipeline to try and hire more staff and create a choice card and everything else. I mean, that is the fallacy of it.

We reported for 10 years on waiting times deficiencies, and it only caught fire in the past year.

Mr. JOYCE. But somewhere in the chain of command people were manipulating data, correct?

Mr. GRIFFIN. That is right.

Mr. JOYCE. Okay. And so the person manipulating that data in order to get a bonus, that is not a theft to you?

Mr. GRIFFIN. The performance appraisals in VHA, as you may know from your time there, might have 100 elements that people are rated on, one of which might be access to care. In many facilities—they are not the same elements. Someone might say, "These are the five biggest challenges we have this year in our network or in our medical center," so the director says, "I am going to go after these five things this year." Access might not be near the top of his list.

Don't misunderstand. It is outrageous. It is outrageous when the principal deputy Under Secretary in VHA sends a letter to the whole system and says, "Stop cooking the books," and says to the leadership out there, "This is how they are doing it. This is how you can catch it." They institute a policy to require certification that their numbers are legitimate, and a short time later they kill the requirement.

It is outrageous. Believe me, I am with you. And I would like every case we investigate to be prosecuted, but I can't control that.

Mr. JOYCE. Well, I think it is ludicrous they have bonuses in place where they can manipulate things to actually get the bonus. People should get paid to do a day's work.

Mr. GRIFFIN. Absolutely.

Mr. JOYCE. And if you don't do the day's work to the best of your God-given ability you should be fired.

Mr. GRIFFIN. Absolutely.

Mr. JOYCE. I see I am out of time, Mr. Chairman, but I will come back later. Thank you.

Mr. DENT. Thank you.

Mr. Jolly.

OPIATE PRESCRIPTIONS

Mr. JOLLY. Thank you, Mr. Chairman. Just a couple quick questions.

You have studied the opiate prescription issue at length several times over the course of the years. What is your system-wide assessment, or your findings, perhaps, from previous reports? I mean, it can't simply be the one location.

Mr. GRIFFIN. Right. Dr. Daigh's team published a national review last May; it identified a half a dozen different problem areas from bad mixing of different drugs and what have you. And we also published nine other individual reports on opioid use.

I would ask David to speak to the national findings.

Dr. DAIGH. So in the timeframe of 2012, which is the data that we were able to look at everybody in V.A. who received opioids, there were a couple of problems that stood out. The percentage of veterans who were on chronic opioids who also have substance use disorder—that is, they are addicted to narcotics of one sort or another—is in the range of 10 or 12 percent. The percent of veterans who, in the same category, have significant mental illness is in the range of 40 percent.

So you have a group of patients that have a very complex chronic disease burden that are very difficult to take care of.

Notwithstanding that, there is a guideline that has been put out by DOD and V.A., that talks about the proper use of narcotics in patients who are taking chronic opioids, and the bottom line is that V.A. providers were not following, really with astounding figures, the advice of the guideline.

So, for example, you are supposed to get a urine drug screen at certain intervals. Wasn't occurring.

You are supposed to not give refills—early refills under certain circumstances. That was also not occurring.

So everywhere we have looked across the system we have seen that as a major problem.

Mr. JOLLY. What triggers a site-specific review for your office?

Dr. DAIGH. At current time, last year we got 2,400 complaints of health care issues that came to my group. That works out to be something like 10 a workday, plus. So we look at those.

A portion of those I don't have the manpower to address so I send a letter to the director of the VISN, usually above the facility, and say, "Please respond to these allegations," having removed the

person who made the allegation, trying to get by the whistleblower issues. We pick about 60 or 70 cases—that is about the workload I have—and we go and look at those.

It is a combination of if everybody is out looking at Phoenix, I have to send some out. If people are in the office and we have the workload then we go out and look at them.

So essentially, it is an allegation either from our doing a CAP and serving employees and hearing that there are problems with narcotic use—we would then trigger a hotline.

Mr. JOLLY. So you are responding, basically, that if you can see site-specific allegations or concerns, and obviously if you see a cluster of them, that is where. Shifting gears real quickly, and I have raised the issue with the Secretary.

INACCURATE DEATH NOTICE

I have only been in office for a year, and at least four times now I have had a constituent come in with a letter from the V.A. expressing their regret at the veteran's passing, but the veteran is actually fully alive. It is very disruptive to their benefits. We work it, and about 2 months later they get a letter saying, "We have reviewed your file and determined you are, in fact, alive."

It is, as you can imagine, disruptive for benefits and so forth.

The secretary has indicated it is something he is working on. He has kind of put it on Social Security.

Has your office ever looked at this? I mean, I realize it is not a crushing issue in everything else you are dealing with, but have you had any exposure to this or looked at this?

Mr. GRIFFIN. We are aware of the anecdotal type stories that you have mentioned, and I don't know what to attribute——

Mr. JOLLY. Okay. That is fine. And it is just a curiosity.

Mr. GRIFFIN [continuing]. Different kind of review or anything.

Mr. JOLLY. I appreciate the Secretary's affirmation that he is looking into it.

Mr. Chairman, no further questions. The only thing I would say on the record is I would hope our subcommittee can find a way to improve on the President's request for OIG.

In this year, in this time window, to give our stamp of approval to a budget for the OIG that requires a reduction of 10 full-time employees is an issue of great concern. If anything, I think we need to be looking at how to improve the resources and personnel to provide the investigations and oversight into the V.A.

So I appreciate it. Thank you.

Mr. DENT. I appreciate the member's comments, and we are going to do our best on that front.

Now I recognize Mr. Fortenberry for 5 minutes.

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Good morning, gentlemen.

BROKERING OUT CLAIMS

Nebraska has one of the highest V.A. rated systems, and we are proud of that. But an ancillary problem to the larger problem of claims processing and patient management load is that Nebraska has taken on work from other states. Now, I think they have gladly done that and absorbed that with the capacity we have, but we

can't get in a situation that starts—where that starts to create backlogs for ourselves.

We have been informed by several groups that that appears to be the case. Are you aware of this dynamic?

Mr. GRIFFIN. We are aware and we have done an audit on the process of brokering out claims. I am from the Heartland myself.

Mr. FORTENBERRY. Well, no wonder you talk so plainly and give straightforward answers. Thank you.

Mr. GRIFFIN. People out there in some of those offices out there would just seem to be able to get the job done. It is cost of living, maybe it is better management——

Mr. FORTENBERRY. Good clean living——

Mr. GRIFFIN. Exactly. But we did a review of this policy that VBA had of shipping around these claim forms, and naturally, if you are the person who owns the claim that is 2 years old you are happy to ship it off to somebody else.

If you are on the receiving end, frequently there is a reason why it is 2 years old. It wasn't a ground ball, or it wasn't something that somebody could grab hold of and quickly dispose of and, and resolve the issue.

We found that the brokered claims that we looked at—and I would be pleased to send a copy of that review up to you so you can have the information in it, actually extended the time period to get the things done——

Mr. FORTENBERRY. Oh, is that right?

Mr. GRIFFIN [continuing]. As opposed to——

Mr. FORTENBERRY. Further complicated the situation?

Mr. GRIFFIN. Yes.

Mr. FORTENBERRY. Well, that is another ripple effect of the initial core problem, so appreciate your awareness of that.

Mr. GRIFFIN. And frankly, when everything is electronic—it is still a work in progress—it will even be easier to electronically transfer a claim to a more productive office, which conceptually might not be a bad idea, but maybe you need twice as many people in your office in Nebraska and then you can do more workload.

CENSORSHIP OF V.A. CHAPLAINS

Mr. FORTENBERRY. I want to turn to a second issue. There are several court cases where—involving V.A. chaplains who were censored and prohibited from applying the tenets of their beliefs. I don't have the latest information on that, but apparently in 2013 several were forced out of the chaplain training program.

Is this something that you investigate to ensure that the V.A. is not acting out of discord or confusion or against legal precedent?

Mr. GRIFFIN. I can tell you we have not investigated that to date. If there is more information that you would like to provide to my staff we will be happy to look into it.

Mr. FORTENBERRY. My own information is a bit limited, but apparently these—this is some—there is a manifestation of some real problem here. But if you would be willing to receive additional information as we get it, that would be helpful.

Mr. GRIFFIN. Please do.

Mr. FORTENBERRY. Thank you, Mr. Chair.

Mr. DENT. Thank you. And if there are other, further questions from any of the members——

Mr. JOYCE. Yes.

Mr. DENT. And before you do, I was going to ask just one question——

Mr. JOYCE. Sure.

Mr. DENT. If it is okay with the ranking member, I would just ask—recognize Mr. Joyce briefly afterwards.

LEGIONNAIRES DISEASE IN V.A. FACILITIES

So with that, I just wanted to ask my other question, Mr. Griffin, on Legionnaires' disease in V.A. facilities. Your office was very active in exposing the Legionnaires' disease patient care problems in some Pennsylvania facilities. In response, the V.A. is using a total of $167 million in the 2015 and 2016 Choice Act funding to make infrastructure changes to prevent the recurrence of the Legionnaires' situation.

Do you think the V.A. plans are sufficient to address this problem?

Mr. GRIFFIN. We did do the specific review in Pittsburgh. We also did a national review.

I am going to ask David to respond to that. It is not unique to V.A. facilities, and there is actually a higher percentage of these problems in the Northeast than there is in other parts of the country. But David could speak more eloquently to the problem.

Dr. DAIGH. Legionella is in everyone's groundwater, so depending on the exact species of Legionella that is in the groundwater where you reside then everyone is at some risk for it. It is a national problem. V.A. does have a national attempt to deal with this problem.

I am not aware of exactly the program you are talking about that would—that you are speaking of for $167 million. I don't know exactly what they are doing.

But clearly there does need to be an effort to try to ensure that the water going into hospitals does not contain pathogens like Legionella. So I haven't looked at that—I don't know what that buys, is what I am trying to say, in order to answer your question directly.

Mr. DENT. Thank you.

Does the ranking member have any additional questions?

Okay. Then we will recognize Mr. Joyce, and then that will end the hearing.

PHOENIX RECOMMENDATIONS

Mr. JOYCE. Thank you, Mr. Chairman.

In your testimony you referred to 24 recommendations that the V.A. made to implement immediate and substantive changes in response to rampant fraud in the scheduling system. As of March 2nd this year, 18 recommendations are still open.

What development have you seen in implementing those 18 remaining recommendations?

Mr. GRIFFIN. You are referring to the Phoenix recommendations——

Mr. JOYCE. Correct.

Mr. GRIFFIN [continuing]. Right?

I would like to give you all 18 for the record, if I may, because I don't have all 18 of them on the tip of my tongue.

Mr. JOYCE. Sure.

Mr. GRIFFIN. One of the principal recommendations was to finally, after many years of abortive attempts to create a viable scheduling system, that the V.A. get that system in place that can be remotely audited. So if someone in a facility is playing games with the numbers, that could be detected remotely by somebody in the main V.A. in the I.T. world or in VHA.

I know that they put out some requests for proposals on how they might do that. There are some off-the-shelf applications; they are being reviewed.

I think from the standpoint of being able to demonstrate a serious requirement being addressed, that would be one of them.

The old system, if a person wanted or if a doctor wanted to see the veteran in 6 months, software wouldn't allow them to schedule it immediately because it was too far out, which is part of the answer, frankly, on some of these paper wait lists. In order to keep track of those to insert them when you were within the window of being able to put them into the system, they maintained separate lists instead of the electronic wait list, which wasn't capable of handling that information.

So certainly one of the key recommendations was on accountability, and that is a work in progress.

I don't know, David, if anything comes to mind.

Dr. DAIGH. There were a number of ethics issues and adjustments they were going to make in terms of how they train their workforce, and there is also the issue of notifying and reviewing the cases we identified where harm had occurred—both of deaths and harm that we had heard. And I don't know exactly where they are on notification for those cases, but that would be part of what we could provide back to you in follow-up.

Mr. JOYCE. Do you feel that it is part of a decentralization? I heard you say that you want to find something where you can remotely check to make sure that the numbers are not being manipulated, and this occurred as a fault of V.A. sort of being decentralized while at these different establishments and it would be better if we had it under a central unit.

Mr. GRIFFIN. As President Reagan once say—said, "Trust but verify."

Mr. JOYCE. Yes. Absolutely.

Mr. GRIFFIN. I think to have the capability to monitor remotely what is going on would certainly put a little strength in the system. I do believe that because this went on so long that people just get blase about it, they didn't think about it.

Over 10 years we did 20 reports on this. We testified 19 times before the Congress. And finally it got traction, thanks to some aggressive oversight from the Hill.

When you have the second or third-highest person in VHA sending out a directive saying, "Knock it off," and making a requirement for certification and then very quickly it is removed, it went to the highest levels, and it certainly existed at the director level

in some facilities. I am not saying everybody, but it was accepted practice.

And it might have been—I mean, if a director said, "We don't have enough doctors to do these things in 30 days," and then the requirement got cut to 14 days, well, if you can't get them done in 30 days you are not going to get them done in 14 days.

I referred to a stretch goal, you want people to stretch and do the best they can, but if it is unrealistic, people in the field might be saying, "What are they thinking about? We are drowning in veteran demand and we don't have the resources to deal with it."

So there needed to be some honesty and say, "Look, we either need twice as much money to do fee basis work, or we need this number of clinicians." But if you don't have staffing standards, it is hard to determine what the number of clinicians is that you need, so we have been beating that drum also.

Mr. JOYCE. It is just astounding, don't you agree, that there are no red flags or bells and whistles that were set off that would have caught this very early in the stages? As you say, it went up the chain of command, and the quick rescission of that must have made everyone think that this is okay, this is standard——

Mr. GRIFFIN. It was a failure in leadership at multiple levels.

Mr. JOYCE. Well, you know, just briefly, what we can do to help you to that effect, please let us know. Because I think everyone here is committed to make sure that it doesn't ever happen again, or we clean up the system that is in place.

And secondly, you know, I know there are a lot of young prosecutors, ladies and gentlemen, in city and county offices who also have veterans in their jurisdiction and would be glad to help you and assist you. I know the Department of Justice is very busy, and that the U.S. Attorney's Offices are busy, but theft is theft, and so any way we could help you or they could help you let us know.

Mr. GRIFFIN. We want to do quality and timely work, and at the current inflow of requests that we get, we can't do it. And it disturbs me greatly.

And as I said earlier, we have a 38 percent increase in requests from the Congress. If you send me a request I don't want to take a year or 8 months or whatever to do it; I would like to turn it around in 90 days possibly—quicker if possible.

But when these things—when you get any of these things like Phoenix—Phoenix consumed half of our staff for the better part of a year. This Philadelphia review just kept growing and growing and growing.

And we want to be part of the solution, and in order to do that you have to be able to do things timely, make solid recommendations that everybody understands, get the department to acknowledge, "Yes, we admit we have a problem," and make them describe the solution, and then we follow up until it happens. That is what we want to do.

Mr. JOYCE. Thank you very much. Good luck.

Mr. DENT. Well, thank you. This concludes our hearing.

I have several more questions I am going to submit for the record, and hopefully you can get back to us on those two questions, which I think you already partially addressed.

So with that, I want to thank everybody for your attendance today.

Appreciate your presence today, Mr. Griffin and Dr. Daigh. At this time, this meeting of the subcommittee is adjourned.

[Questions for the Record submitted by Congressman Dent for the Deputy Inspector General Richard J. Griffin follows:]

Question: How many VA employees are under investigation by the Department of Justice for criminal behavior associated with the wait list scandal?

VA OIG Answer: As of March 26, 2015, a total of 79 VA employees have been named as subjects in the OIG's investigations regarding wait time manipulation. We presented evidence of alleged criminal conduct against 43 employees to the Department of Justice (DOJ) but they declined to prosecute, citing lack of criminal intent, lack of identifiable patient harm, and the prevalence of scheduling manipulation as an accepted practice across VA as some of the reasons for the declinations. In these cases, we referred the evidence to the VA Office of Accountability Review for their determination on whether VA should take administrative action against these employees. We also referred evidence of alleged misconduct against 26 other employees to OAR; these cases were not presented to DOJ because of the lack of evidence that a crime had occurred. Ten cases are pending with DOJ for a prosecutive determination.

[Questions for the Record submitted by Congressman Dent for the Deputy Inspector General Richard J. Griffin follows:]

Question: The waitlist situation must have required you to reallocate staff efforts from other activities. What capacity do you have to transfer staff with the necessary skills from one activity to another? Or do you have to hire new contract staff for unanticipated activities?

VA OIG Answer: At its peak period in the summer of 2014, the OIG had 300 staff members dedicated to work on allegations of patient deaths and waiting times manipulation at the Phoenix, Arizona, Health Care System, and to what has grown to 98 other Veterans Health Administration sites. We were able to issue an interim report in May 2014 and a final report in August 2014 due to the exceptional collaborative efforts and hard work of personnel across a range of occupational disciplines in the OIG's four directorates both in the field and at OIG headquarters: the Office of Investigations, the Office of Audits and Evaluations, the Office of Healthcare Inspections, and the Office of Management and Administration. The synergy evidenced at Phoenix and elsewhere was not a random occurrence; rather it resulted from OIG senior leadership's long term emphasis on the value and recognition of team work and collaboration, which are critical performance elements for all OIG employees. Inevitably nearly every year a major unplanned project arises that demands cross-directorate work effort, which with proper executive planning, prioritization, and direction, the OIG has been able to meet. We have not relied on contractor staff to meet these unanticipated activities.

[Questions for the Record submitted by Congressman Dent for the Deputy Inspector General Richard J. Griffin follows:]

Question: You have established a new policy that public release of administrative closure would be decided centrally. Could you tell us what the new central policy will be on releasing reports? Will all completed reports, even those with confidential information and unsubstantiated allegations and those where agency actions have been take to correct problems, be released (with appropriate redaction)?

VA OIG Answer: The new policy requires publication of all Office of Healthcare Inspections administrative closures on the OIG public website. Prior to publication, the OIG Release of Information Office will review and redact any sensitive information. We continue to believe that administrative closures are a necessary tool to document OIG work efforts that do not result in productive findings or when a project is discontinued due to reasons such as the filing of a Tort Claim against VA.

[Questions for the Record submitted by Congressman Dent for the Deputy Inspector General Richard J. Griffin follows:]

Question: Please give us your assessment of the actions that VA is taking to use a total of $167 million in 2015 and 2016 Choice Act funding to make infrastructure changes to prevent recurrence of the Legionnaire's situation. Do you think that the VA plans are sufficient to address the problem?

VA OIG Answer: VHA provided OIG with a description of the $167 million provided for *Legionella* prevention and control improvements in Section 801 of the Choice Act. This spend plan identifies approximately 42 sites where construction activities will be undertaken to lessen the likelihood that patients will be infected with *Legionella* while at a VA hospital. Of the $167 million, $67.85 million will be spent to update water system drawings, as required by VHA Directive 1061- Prevention of Healthcare-Associated Legionella Disease and Scald Injury from Potable Water Distribution System.

Legionella is endemic in the ground water of the United States. The completion of selected non-recurring maintenance construction projects, and updating VA hospital water system drawings, are reasonable actions to limit the likelihood that hospital water systems become contaminated with *Legionella*. These steps alone will not prevent veterans or staff from becoming infected with *Legionella*. When combined with clinical monitoring, the likelihood of an outbreak of *Legionella* at VA hospitals is substantially lessened. Non-recurring maintenance requirements to address the risk of waterborne illnesses will be a recurring issue for hospitals.

[Questions for the Record submitted by Congressman Dent for the Deputy Inspector General Richard J. Griffin follows:]

Question: Is the IG Office of Contract Review required to regularly review VA construction documents?

VA OIG Answer: Under the Memorandum of Understanding between the Office of Inspector General and the Assistant Secretary for Acquisition, Logistics, and Construction (OALC), the Office of Contract Review (OCR) performs pre-award and post-award contract reviews and other pricing reviews of Federal Supply Schedule, construction, and health care provider contracts. However, VA does not require contracting officers to seek review of construction contracts. Pre-award reviews of proposals, audits of claims, and audits of change orders are performed by OCR upon request of VA contracting officers or OALC.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

Question: According to the FY 2016 budget documents, the IG's budget request is only a 0.3 percent increase over last year's level and will result in a 10 FTE reduction. What effect will that have on the ongoing IG investigations? What would the IG be able to do with additional resources?

VA OIG Answer: The reduction of 10 Full Time Equivalents (FTE) will not affect ongoing investigations, audits, and inspection activities but will impact the OIG's ability to provide a commensurate level of oversight during fiscal year (FY) 2016 as is planned for FY 2015. The OIG requires additional resources to address the increased demand for oversight associated with the significant expansion of VA programs overall. Additional funding will support an increased number of healthcare inspections nationwide, which are necessary to address access to care and patient quality standards; strengthen the OIG's capacity to review and coordinate Hotline contacts and congressional requests, which have increased 45 percent and 38 percent respectively since FY 2013; support additional audits and evaluations in program areas expanded under the *Veterans Choice Act*, including non-VA care, facilities construction, and information technology; and allow for ongoing inspections and oversight of the Veterans Benefits Administration (VBA) and VA regional offices. Additional funding will also support an increased number of investigative actions related to drug diversion; fraud in the areas of procurement, fiduciary, and Service-Disabled Veteran-Owned Small Businesses; threats and assaults; identity theft; and serious misconduct by senior VA officials.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

Question: It is interesting that the IG funding level is flat because OIG operations actually provide a return on investment of $22 in monetary benefits for each $1 of OIG resources expended, including recoveries returned to the Government of $3 for every $1 of OIG resources. Can you explain the different ways this money is recovered and how is it reinvested back into the VA?

VA OIG Answer: The return on investment of $22 to $1 achieved during FY 2014 reflects the identification of $2.3 billion in monetary benefits. Monetary benefits reflect cost savings and recoveries identified across multiple program areas including: Better Use of Funds ($318.7 million); Savings and Cost Avoidance ($664.9 million); Questioned Costs ($957.1 million); Fines, Penalties, Restitutions, and Civil Judgments ($91.2 million); the Fugitive Felon Program ($240 million); and Dollar Recoveries ($28.2 million).

Fines, penalties, restitutions, civil judgments, and other dollar recoveries are eventually returned to the U.S. Treasury and in some instances to VA's Revolving Supply Fund. Since FY 2011, OIG has achieved a recovery return on investment of $5.5 for every $1 in budgetary resources expended. The return of these funds, generated by the efforts of the OIG, provide a considerable benefit to the taxpayer and VA. OIG does not track VA's use of these funds as they are not returned to the OIG.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

Question: Are there any concerns that your current request, if funded at that level, will hurt Veterans in critical areas such as healthcare or claims processing because issues will go unidentified?

VA OIG Answer: Yes, from FY 2012 through FY 2015, the total VA budget increased 36 percent, nearly 3 times the rate of the OIG budget for the same period. The expansion of VA health care and benefits programs during this time, as well as VA's planned investments using Choice Act funding warrant a proportionate increase in OIG oversight capacity. The President's proposed FY 2016 budget will not support the staffing necessary to properly address the 45 percent increase in Hotline contacts and the 38 percent increase in requests from Congress received since FY 2013 concerning patient safety, access to care, and quality of care issues; conduct additional inspections of health care facilities; coordinate national audits and evaluations of veterans benefits; or investigate high risk programs and allegations of fraud, waste, abuse, or other criminal activity.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

Question: How many findings does the IG have against the VA currently and does the VA have a resolution process and a timeline for remedy?

VA OIG Answer: As of March 30, 2015, there a total of 208 open OIG reports and the number of open recommendations contained in these reports totals 1,140. The majority of the open reports (166) and recommendations (979) are assigned to VHA. Most reports and recommendations are on schedule to close within 1 year of report issuance based upon VA's response and proposed action plans submitted to the OIG.

In order to track VA's progress toward report and recommendation implementation, the OIG operates a centralized follow-up office to track open OIG recommendations. Our process is:

- Approximately 90 days after report issuance (and every 90 thereafter until report closure), the OIG will send a status update request to the VA action office(s) to which the recommendations are addressed.
- Within 30 days of receiving the status update request, each VA action office is expected to submit a response to OIG's Follow-Up staff describing the progress made towards implementing each open recommendation.
- OIG Follow-Up staff and the OIG line staff who prepared the report analyze the response to determine whether the VA action office implemented the recommendations to the satisfaction of the OIG.
- Closure of a recommendation is not be based on mere assertion of implementation by the VA action office, but will be based on supporting documentation indicating the corrective action has occurred or has sufficiently progressed to close the recommendation as implemented.
- The follow-up cycle will repeat until the VA action office implements all open recommendations. Once all open recommendations are implemented, OIG Follow-Up staff will issue a closure memorandum to the VA action office.

Additionally, we provide the Secretary, Deputy Secretary, and Chief of Staff with a detailed status report twice a year on overdue recommendations. Moreover, in each *Semiannual Report to Congress*, there is a listing of reports in Appendix B: Unimplemented Reports and Recommendations.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

VA CONSTRUCTION

Question: According to your testimony one of your areas of concern is with VA construction and I too share your concern. The IG recommended for the VA to establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities and establish central cost tracking to ensure transparency and accurate reporting on Health Care Center expenditures. Has the VA taken these steps? Could these controls have helped with the situation in Denver?

VA OIG Answer: Our report, *Review of VA's Management of Health Care Center Leases*, included four recommendations. Only one recommendation remains open:

- Recommendation 1: We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction, in coordination with the Under Secretary for Health, establish adequate guidance for the procurement of large-scale build-to-lease facilities.

This recommendation was focused on build-to-lease facilities. It is unclear if similar controls for major construction projects such as construction of new VA Medical Centers would have prevented the situation with the Denver VA Medical Center. The Office of Audits and Evaluations is planning a project to review the adequacy of controls over resources, technical expertise, and management information systems; change management controls; the effectiveness of VA's Construction Review Council established in 2012; and other lessons learned from this and other VA construction projects. We plan to start this review in April 2015.

The decision by the U.S. Civilian Board of Contract Appeals (CBCA 3450 Decision Granted December 9, 2014) provides an in-depth analysis of what VA did and did not due which caused the problems. We have attached the decision for your review.

3 of 34 DOCUMENTS

KIEWIT-TURNER, A JOINT VENTURE, Appellant, v. DEPARTMENT OF VETERANS AFFAIRS, Respondent.

CBCA **3450**

United States Civilian Board of Contract Appeals

2014 CIVBCA LEXIS 370; 2015-1 B.C.A. (CCH) P35,820

December 9, 2014

PRIOR HISTORY:
Kiewit-Turner v. VA, 2014 CIVBCA LEXIS 80 (2014)

COUNSEL:
[*1] William E. Dorris, Chad V. Theriot, Reginald A. Williamson, and Damian M. Brychcy of Kilpatrick Townsend & Stockton LLP, Atlanta, GA; and Michael A. Branca of Peckar & Abramson, P.C., Washington, DC, counsel for Appellant.

Charlma Quarles, Stacey North-Willis, Khaliah Wrenn, Benjamin Diliberto, and Eyvonne Mallett, Office of General Counsel, Department of Veterans Affairs, Washington, DC, counsel for Respondent.

JUDGES: Before Board Judges DANIELS (Chairman), POLLACK, and STEEL (presiding). HOWARD A. POLLACK, Board Judge, CANDIDA S. STEEL, Board Judge, concurring.

OPINION BY: DANIELS

OPINION:

DANIELS, Board Judge.

In an earlier decision in this case, we held that the appellant, Kiewit-Turner, A Joint Venture (KT), may seek declaratory relief regarding the following three questions: (1) Did the contract modification known as SA-007 obligate the respondent, the Department of Veterans Affairs (VA), to provide a design that could be built for $ 582,840,000? (2) Did the VA materially breach the contract by failing to provide a design that could be built for that amount of money? (3) If such a breach occurred, is KT entitled to stop work? *Kiewit-Turner, A Joint Venture v. Department of Veterans Affairs, CBCA **3450**, 2014-1 BCA P 35,705.* [*2] After hearing testimony for eight days, reviewing a voluminous documentary record, and considering lengthy briefs and reply briefs submitted by the parties, we now answer each of these questions in the affirmative.

Findings of Fact

On August 31, 2010, the VA awarded to KT a contract for the performance of pre-construction services on a medical center campus in Aurora, Colorado. The contract included an option for the performance of construction services as well. The contract was described as an "integrated design and construct," or IDc, type contract -- something similar to the "construction management at risk" or "construction management as constructor" types of contract used in the private sector.

Under an IDc contract, the construction contractor is brought into a project early, to analyze the design and give advice on the basis of which the owner can either direct its design team -- with which it contracts separately -- to make design changes, or alternatively, procure additional funds. James Lynn of Jacobs Engineering Group, Inc. (Jacobs), the VA's construction manager for this project, explained that "[t]he only way any kind of early contractor involvement type of approach [*3] works is if there's true collaboration and a level of trust built between the parties, the owner, architect and contractor." The VA had never used this type of contract before. The agency's own project management plan recognized as a high risk that "IDc represents new contracting approach for VA; does not fit existing procedures which is complicated by VA culture that does not encourage or is [not] comfortable with new approaches."

Indeed, the VA did not use the IDc mechanism properly right from the start. At the time KT was brought into the project, the design team -- a joint venture team (JVT) consisting of Skidmore Owings & Merrill, S.A. Miro, Cator Ruma, and H+L Architects -- had already been under contract since January 2006, and after a hiatus of nearly two years, had been at work since November 2007. n1 By August 2010, the design was already at the Design Development (DD) -1 stage (50% complete) n2 and funding decisions had been made. This limited the agency's flexibility to make modifications based on KT's pre-construction services advice. A September 2011 review by the Army Corps of Engineers, which was commissioned by the VA, confirmed that the IDc contract was not properly [*4] used: "[T]he IDc contract type may have not been appropriate for the Medical Center Replacement in Denver. . . . [P]roceed[ing] with design development to major design milestones (DD1) prior to procurement of the IDc contractor . . . did not permit the IDc contractor to integrate with the designer to achieve the benefits related to this contract type. . . . The current methodology appears to be counterintuitive to the Government's ability to achieve best value." n3

n1 The design team was also referred to as "A/E" or "AE," meaning architect/engineer.

n2 The project consisted of numerous buildings, and the design (and later, the construction) proceeded more quickly on some buildings than others. Nevertheless, both during contract performance and in briefs, the parties refer to stages of design as if the process was unitary. We follow this practice in this opinion.

n3 This was merelyone instance of VA management problemson the project. The record is replete with instances in which the agency's on-site personnel -- project executive, senior resident engineer, resident engineers, contracting officer, and project coordinator for the medical center -- lacked confidence in each other's abilities and respect for each other's actions. Jacobs' Mr. Lynn described this group, prior to a shake-up in June 2013, as the least effective and most dysfunctional staff on any project that he had ever seen.

[*5]

A key early VA funding decision was establishing a construction cost target, known as the estimated construction cost at award, or ECCA, at $ 582,840,000. This ECCA was prescribed, on the same day as the KT contract was awarded, through a modification to the JVT's contract.

Notwithstanding the strictures imposed by the VA, KT devoted considerable manpower to pre-construction activities and submitted numerous reports to the agency. KT informed the VA at many stages that the design lacked coordination and completeness, that the design was over budget and included elements that were above the standard for a healthcare facility, and that value engineering (VE) was not being incorporated into the design.

The VA did not criticize KT's pre-construction work. To the contrary, both the VA's project executive for this

project until June 2013 and agency counsel acknowledged at our hearing that the contractor fulfilled all of its pre-construction contractual requirements. The pre-construction services are not at issue in this case.

As early as October 2010, an independent advisor was cautioning the VA's project executive that the costs of the project, per the then-current design, were increasing. [*6] In November, the project executive's supervisor told him that "[the] DD1 packet is unsatisfactory and the JVT is not listening to the directions they are given from the user [side] or from the CFM [VA Office of Construction and Facilities Management] side." In January 2011, KT estimated that the design would cost $ 589 million to construct; the JVT essentially agreed, putting the figure at $ 587 million. In April 2011, KT estimated that the design, which was then at the DD-2 stage (65% complete), would cost $ 659 million to construct. This figure was $ 76 million more than the ECCA. (KT later revised this estimate to $ 664 million.) Although estimates of construction costs made by KT and the JVT were supposed to be reconciled at each stage of design, this KT estimate was not reconciled with the JVT's estimate.

Nevertheless, the VA asked KT to prepare a proposal for the optional work under its contract -- constructing the medical facilities. In July 2011, the parties agreed that KT would submit a firm target price (FTP) proposal in the amount of $ 603 million. On August 25, 2011, KT submitted such a proposal. The price was $ 599.6 million for construction itself and $ 3.4 million [*7] for all pre-construction activities, with a ceiling price of $ 609 million. The FTP was based on a detailed analysis of DD-2 enhanced drawings. The proposal included many pages of general, technical, and pricing clarifications, which noted assumptions on which the proposal was based. We credit the testimony of KT's former managing partner that including these sorts of assumptions and qualifications in a proposal is typical in the commercial world for an IDc-type contract where the design is incomplete. The proposal assumed that the VA would ensure that the design include $ 23 million of value engineering (VE) items and that KT would negotiate price reductions of nearly $ 31 million from its subcontractors. KT's detailed FTP proposal became known as "The Book."

By the time that KT submitted its proposal, the VA also had in hand an independent estimate prepared by Jacobs which showed that the cost of construction would be $ 677,697,408.

Over the next two months, KT and the VA negotiated regarding KT's proposal, with KT frequently modifying pages of The Book to show agreed-upon changes. On October 4, KT submitted a revised Book. Negotiations continued, and by the end of October, only [*8] one item, an economic price adjustment clause proposed by KT, remained in dispute.

Mike Rossi of VCI, a company which had been engaged by the VA to advise it on early contractor involvement contracts, recommended to the VA that it not conclude a FTP until drawings were complete, since proposals at an earlier stage of design development would necessarily involve contingencies. The VA did not follow his suggestion, however. It scheduled a meeting for November 9, 2011, in an attempt to finalize a FTP. Participants included high-level representatives from KT and the VA, as well as Mr. Lynn of Jacobs. Chris Kyrgos, the VA contracting officer's supervisor, traveled from Washington, D.C., to Denver for the meeting.

Mr. Kyrgos demanded that KT remove the clarifications, qualifications, and assumptions from The Book and present a proposal based on the most recent set of drawings. KT responded that the clarifications, qualifications, and assumptions were necessary and reasonable given the state of the drawings on which the proposal was based. KT maintained, and the contracting officer agreed, that it would need several weeks to price the new drawings. KT's managing partner explained further [*9] that in light of the contractor's estimate that the current design would cost more than $ 664 million to construct, KT could not possibly build the project for only $ 603 million. KT and VA participants both testified that Mr. Kyrgos refused to consider negotiations based on The Book. The negotiations appeared to be at an impasse.

At this point, Mr. Lynn stepped forward to act as a mediator. He proposed that if the VA would agree to present a set of drawings that could be constructed for the ECCA, KT would agree to perform the construction work for the price

it had offered. He then drafted a handwritten statement entitled "Agreements -- Path Forward." The three key paragraphs of this statement read:

> 1. All parties agree that they must get price to $ 604 mil. They will each expend resources to keep that goal.
>
> 2. VA shall cause JVT to produce a design that meets their ECCA with use of alternates and other methods as a safety net.
>
> 3. Agreed: . . . FTP set to $ 604m[illion]/clg.[ceiling]@610.

The difference between the ECCA of $ 582,840,000 and the FTP of $ 604 million was that the latter included pre-construction and off-site infrastructure work, as well [*10] as other items, but the former did not.

The contracting officer and others signed the statement on behalf of the VA; the managing partner and another individual signed it on behalf of KT. Both parties understood that by making this agreement, the VA recognized that it would have to ensure that through the use of VE and other means, the JVT would produce a design which could be constructed for less than the current estimated cost of the project. KT's managing partner testified that "[t]he big caveat there is they have to produce a design that meets the ECCA because the current design didn't come anywhere close to that." Mr. Lynn testified that including paragraph 2, regarding the ECCA, broke the impasse. The agreement did not reference any particular set of drawings; it contemplated that a future design would meet the ECCA.

Within two days after this Path Forward agreement was signed, KT sent to the contracting officer a new FTP proposal for construction work which was a mere page-and-a-half long. This proposal reiterated the contents of the agreement and did not reference any particular set of drawings or any part of The Book. A week later, KT's managing partner and the VA contracting [*11] officer agreed to modification SA-007 to the contract, exercising the agency's option to have KT perform construction work and establishing a FTP of $ 604,087,179. Modification SA-007 included these paragraphs:

> 10. Both parties agree that they must achieve a goal to get the project price at or below $ 604,087,179.00. Both parties agree to expend the necessary resources to keep the project goal.
>
> 11. The VA shall ensure the A/E (Joint Venture Team) will produce a design that meets their Estimated Construction Cost at Award (ECCA) with use of alternate and other methods as a safety net.

Like the handwritten agreement, but unlike documentation used in prior negotiations, SA-007 does not mention any particular set of drawings. Demonstrating that both parties understood this, in March 2012, KT's deputy managing partner and the VA contracting officer gave to personnel from both parties a presentation entitled "SA-007 and Managing to the $ 604M." The presentation asked, "Does SA-007 clearly define the scope of work?" and provided the answer, "No. Defines the box." The VA adhered to this understating well into 2013. In January of that year, the facilitator of the "blue ocean" [*12] meeting (see below) wrote in her summary, "It was noted by the VA that the $ 604 MM Firm Target Price agreement between the VA and KT was not based on any set of design documents." In April, at a meeting with the JVT, Mr. Kyrgos stated that "only what is stated in the SA[-007] document itself has relevance [to the VA-KT contract]. Any previous document used in negotiations has no relevance or weight in this contract."

On November 18, 2011 -- the same day on which modification SA-007 was signed -- the VA issued to KT a notice to proceed with the construction work. At that time, KT expected, based on communications from the VA, to receive 100% complete construction documents by the end of January 2012. In late 2011, however, the VA let lapse its architect/engineer peer review contract, and without a peer review, the agency would not release the 100% design package. The package was then projected to be delivered by April 2012. On April 5, 2012, KT told the VA that the "lack of this information is currently creating numerous negative impacts in material procurement/fabrications,

obtaining approvals of submittals, coordination of trades, putting work in place in the field, as well [*13] as obstructing our ability to maintain the schedule as currently planned." The next day, KT sent another letter, documenting the delay and its impact for each design package. KT followed this with yet another missive on May 8 on the same subject. While awaiting the 100% documents, KT proposed that it solicit subcontractor bids based on 95% drawings, but the VA rejected this request.

The 100% documents were finally delivered to KT on August 31, 2012. These documents turned out to be far from finished, however. An architect working for Jacobs estimated that the drawings were only 80% complete. The JVT later had to supplement them with an unusually large number of joint supplemental instructions (JSIs), some of which -- including redesign of two parking garages and the energy center -- were significant. The incomplete design, and changes to it, also prompted KT to issue an unusually large number of requests for information (RFIs), seeking clarification as to design elements. Responses to RFIs were often late and/or incomplete. The JSIs and RFIs further delayed procurement of subcontractor work. The VA had known about the incompleteness of the purported 100% design in June 2012, when [*14] the JVT had told the agency that more than 1400 design changes requested by the medical center would not be included in the August drawings.

KT planned to subcontract about 85% of the work on this project. All subcontracts valued at $ 300,000 or more were required by the contract to be secured through a competitive process in which at least three bids were made. The subcontracting process required consent to each subcontract from the VA's contracting officer.

By the fall of 2012, according to witnesses from KT, the VA medical center, and a VA resident engineer on the project, prospective subcontractors were reluctant to submit bids for project work because subcontractors were not being timely paid for work they had performed. Sureties were also refusing to participate in the project due to the lack of timely payment to subcontractors. The VA's incomplete design, failure to process change orders from the spring of 2011 to the spring of 2012, failure to process JSIs in a timely fashion, and failure to make timely payment to KT were the cause of this predicament. Those firms that did bid on subcontracts increased their prices to account for the risk of not being paid timely, or even [*15] not being paid at all. A VA resident engineer wrote in December 2012, "The bad name of this project is on the street. No one wants to bid on this project." At the same time, more buildings were being built in the Denver area, further depleting the number of firms interested in bidding on this project and increasing the amounts of the bids that were submitted.

A September 2011 project management plan prepared by the VA and Jacobs noted "project is over budget" as a risk. The plan stated, "Problem with scope and design management has caused budget overruns." It said that this risk had a high probability and that "extensive VE" was required to reduce it. Compounding the problem, the plan said, was that the JVT did not recognize the problem's existence.

When the plan was updated in July 2012, the same problem was identified. Mr. Lynn explained that a principal contributor was the JVT's reluctance to participate in the VE process. By March 2013, in another iteration of the report, the VA expressed concern that the project might be $ 200-300 million over budget.

Meanwhile, according to detailed estimates, the project's cost was increasing. A report of a weekly meeting in January 2012 [*16] showed that the project was considered at that time to be $ 56.7 million over budget. In March 2012, KT cautioned the VA that the cost was trending above $ 700 million. In April, Jacobs pegged that cost, based on the 95% drawings extant at the time, at $ 712 million. KT thought the cost, based on those drawings, was $ 717 million. The JVT, on the other hand, gave an estimate of $ 607 million. Mr. Lynn told the VA project executive that "massive VE" would be required to bring the price down to that level, and that "because JVT does not believe there is actually a budget issue, they are not fully cooperating with the VE process." KT's deputy managing partner explained to the VA project manager, in August, that the JVT's cost estimates were unrealistically low because they were not based on market research or actual bids, and incorporated improper quantity estimates.

As subcontractor pricing became available, KT informed the VA that costs were increasing further. By December

2012, KT estimated the cost at nearly $ 769 million, even if VE changes of $ 50 million were incorporated into the design. A VA resident engineer told associates he believed the final cost would exceed $ 800 million. [*17] In January 2013, Jacobs estimated, based on purported 100% drawings, that the cost would be $ 784,963,063. (The VA did not inform KT of this estimate until much later.) In March, KT submitted to the VA a firm fixed price proposal, based primarily on competitive subcontractor bids, in the amount of $ 897,584,831 (with clarifications and qualifications). The VA rejected this proposal, with the contracting officer stating that the agency "will continue to hold Kiewit-Turner responsible to the firm target price and ceiling price established in SA-007." (The parties never agreed on a firm fixed price, as opposed to a firm target price, for KT's work.) In June, KT told the VA that the cost could be as high as $ 1.085 billion.

Like Jacobs, the JVT provided to the VA a cost estimate based on purported 100% drawings. This estimate was prepared by a subcontractor to the JVT, Rider Levett Bucknall (RLB), using parameters issued by the VA and under direction from the JVT. RLB's lead estimator testified that he has no idea whether the criteria his firm used in making the estimate accurately reflected project conditions; creation of the estimate was merely an academic exercise. He stated that his [*18] firm was expressly told not to consider the impact of payment issues on subcontractor pricing. RLB estimated, given the constraints under which it was operating, that the project would cost $ 645 million. In February 2014, it lowered the amount, after a review by the JVT, to $ 630 million. The VA adopted this figure as the "independent government estimate." Even at the amount of $ 630 million, JVT members complained that the estimate was $ 48 million over the ECCA and would cause the JVT to have to redesign the project to lower its cost.

At times, the VA did make efforts to cause the JVT to modify the design to meet the ECCA of $ 582,840,000. In September 2011, the agency's project executive and contracting officer issued a critical performance evaluation of the designer. They complained that the JVT had chosen form over function, placed an over-emphasis on aesthetics, had produced an unnecessarily complex design, did not believe that a budget problem existed, and was often uncooperative with the agency. In December 2011, the contracting officer denied the JVT's request for release of retainage, "[d]ue to the ECCA above the contract stated limit and the complete design has not been [*19] accepted." In March 2012, the contracting officer reminded the JVT that under its contract, when bids exceeded the estimated price, the JVT had to "perform such redesign and other services as are necessary to permit contract award within the funding limitation." In May 2012, he wrote, "The Government will work with JVT to incorporate VE items that will bring the cost of the project back to the ECCA." In January 2013, after receiving the Jacobs estimate based on purported 100% drawings, he told the JVT, "The current design . . . exceeds the estimated cost of construction at award (ECCA) of $ 582,840,000.00 by an estimated $ 199,160,000.00. . . . [T]he Government . . . directs [the JVT] to perform redesign and other services to provide a design within the funding limitations." The contracting officer's supervisor, Mr. Kyrgos, acknowledged to others in the VA, "[The JVT] appears to have misled the VA [i]n delivering a project way above the 'design to cost.'"

At many other times, however, the VA acted in a contradictory fashion. In March 2013, after telling the JVT to redesign the project to the ECCA, the agency directed KT to proceed with construction based on the drawings current [*20] at that time. KT complained in response, "KT cannot construct a project within the bounds of the FTP if the design exceeds the ECCA by approximately $ 199 million. . . . [B]y directing KT to construct the current 100% design that the VA recognizes is in need of a substantial redesign, the VA is quickly creating a massive funding issue on this project." In a separate letter of the same date, KT asserted, "[T]he VA cannot direct KT to work beyond the current funding limitations. This means that the VA cannot direct KT to complete the project as reflected in the current 100% design unless and until additional funding is allotted and the FTP and ceiling prices are increased." The contracting officer was unmoved; he responded, "[T]he Government is holding Kiewit-Turner responsible to the firm target price and ceiling price established in SA-007."

According to all the estimates which were made, the cost of the project was at all times higher than both $ 582,840,000 -- the amount to which the VA in SA-007 committed to be the cost of construction -- and $ 604,087,179 -- the amount to which both parties agreed CBCA **3450** in that contract modification would be the total project price for [*21] KT's services. The VA, Jacobs, and KT did expend significant amounts of resources, as required by SA-007, to try to reduce costs. After signing the modification, KT, realizing that the cost already exceeded these figures, brought on

as many as thirty personnel specifically to work on VE efforts. The contractor enlisted some of its subcontractors to generate VE ideas as well. KT proposed many multi-million-dollar VE changes to modify the design so as to bring it within budget. Most of them were rejected by the VA. Often, however, even if a VE proposal was approved at all levels of the VA, the JVT refused to incorporate it into the design, and notwithstanding prodding by Jacobs, the VA did not press the JVT to take appropriate action.

In January 2013, immediately after receiving the Jacobs cost estimate of $ 784,963,063, the VA brought together KT and the JVT to discuss how the project might be redesigned to be within budget. A VA executive explained that "the VA's intent [was] to focus on the JVT's obligation to deliver a design at or below the ECCA." The three-day meeting which ensued -- called the "blue ocean" meeting -- was devoted to brainstorming to develop cost-cutting ideas. [*22] More than seventy ideas, valued at over $ 400 million, were advanced. The Jacobs subcontractor employee who facilitated the meeting considered that $ 157 million of the suggestions could be classified as "easy/like acceptance" or "local approval only required." Personnel at the medical center reviewed the ideas and determined that over $ 140 million were "acceptable" and an additional over $ 100 million were "undesirable but will live with."

Mr. Lynn testified that despite his efforts to secure agency determinations on the blue ocean proposals, the VA would not make decisions on them. The agency tells us in its brief that it ultimately accepted only about $ 10 million of the blue ocean ideas. Others were said to have been rejected on the grounds that they required waivers from federal mandates; violated VA energy, physical security or redundant system requirements; or proposed reductions of scope that would negatively impact patient care.

In April, VA headquarters executives became concerned about the agency's position on this project. One of them wrote to another, "We sent a letter to the [JVT] that the design was over the ECCA by $ 199 million? Can we get a copy of that letter [*23] so we can see the context before we all go to the roof and jump[?]" Also in April, Mr. Kyrgos asked the JVT to "prepare an estimate based on 100% CDs [construction documents]. . . . VA stated that this will become the IGE [independent government estimate]. . . . VA directed that the JVT estimate should not be influenced by actual amounts."

In May 2013, the contracting officer -- without informing KT -- directed the JVT "not to incorporate any of the changes included in the attached list into the Construction Documents." A month later, he wrote to the JVT, "Please do not proceed with any cost-cutting items from the January 2013 meeting." Also in June, the VA's director of cost estimating determined that the Jacobs estimate of nearly $ 785 million should be rejected because Jacobs' failure to use actual known costs was a "fatal flaw" that undermined the reliability of the estimate. (The reason that Jacobs had not used actual known costs, however, was that the contracting officer had specifically directed the firm not to use them. The contracting officer did not disclose this fact to the cost estimating director.) And the contracting officer told KT that it must use pricing from [*24] The Book, the contents of which had been made irrelevant when SA-007 was agreed to, as the basis from which pricing change orders would be considered.

On April 30, 2013, KT requested a final decision from the contracting officer as to whether the VA had breached its obligation under the contract to provide a design that could be built for the ECCA of $ 582,840,000 and whether KT consequently had the right to suspend work. The contracting officer issued a decision denying that the VA had breached the contract and directing KT to proceed with construction of the project. The agency has no plans to redesign the project. According to VA witnesses, the agency has approximately $ 630 million appropriated for construction of the project. The agency has never sought additional funds for the project, and according to deposition testimony given by VA executives in April 2014, there were no plans at that time to ask for more money. A KT executive testified at our hearing in June 2014 that KT had already financed $ 20 million worth of work for which it had not been paid and projected that this figure could reach $ 100 million by December 2014.

Discussion

We address below the three questions [*25] posed by KT.

(1) Did contract modification SA-007 obligate the VA to provide a design that could be built for $ 582,840,000?

SA-007 could not be more clear: "The VA shall ensure the A/E (Joint Venture Team) will produce a design that meets their Estimated Construction Cost at Award (ECCA) with use of alternate and other methods as a safety net." The ECCA was $ 582,840,000 at the time that SA-007 was agreed to, and it remained at that number throughout the period discussed in this decision. Because the language is unambiguous on its face, its plain language dictates an affirmative answer to the question. *Coast Federal Bank, FSB v. United States, 323 F.3d 1035, 1040-41 (Fed. Cir. 2003)*; *McAbee Construction, Inc. v. United States, 97 F.3d 1431, 1435 (Fed. Cir. 1996)*. Use of the words "shall" and "ensure" demonstrates that the VA must make certain that the design will meet the ECCA. *Corey H. v. Board of Education of City of Chicago, 995 F. Supp. 900, 913 (N.D. Ill. 1998)* (citing *Webster's II New Riverside University Dictionary* 434 (1994)).

"Although extrinsic evidence may not be used to interpret an unambiguous contract [*26] provision, [the Court of Appeals for the Federal Circuit has] looked to it to confirm that the parties intended for the term to have its plain and ordinary meaning." *TEG-Paradigm Environmental, Inc. v. United States, 465 F.3d 1329, 1338 (Fed. Cir. 2006)*. The extrinsic evidence here confirms that the SA-007 paragraph regarding the ECCA means exactly what it says. The VA's commitment to produce a design that could be built for the ECCA was the key to the parties' agreement. During the critical negotiating session, before the contents of this paragraph were broached, the parties were at an impasse -- the VA was insisting that the project as then designed be constructed for a specific price, and KT was adamant that unless it could condition its price or have an opportunity to assess costs in light of the then-current design, it would not commit to any price. The ECCA provision broke the impasse: the VA would have the JVT produce a design which could be built for the ECCA, and KT would perform the construction work for the FTP. Without the ECCA provision, KT would not have agreed to do its work for the FTP.

The VA recognized its obligation to require the JVT to produce [*27] such a design not only during the negotiations, but also for at least the next seventeen months. SA-007 was signed in November 2011. The next month, the contracting officer complained to the JVT that its design was in excess of the ECCA. Both then and throughout 2012, VA officials expressed concerned that the design was over budget, with the budget figures being pegged to either the ECCA or the FTP. In May 2012, for example, the contracting officer wrote, "The Government will work with JVT to incorporate VE items that will bring the cost of the project back to the ECCA." In January 2013, after the VA received the Jacobs estimate based on purported 100% drawings, the contracting officer told the JVT, "The current design . . . exceeds the estimated cost of construction at award (ECCA) of $ 582,840,000.00 by an estimated $ 199,160,000.00. . . . [T]he Government . . . directs [the JVT] to perform redesign and other services to provide a design within the funding limitations." The agency then organized the "blue ocean" meeting for the purpose of bringing the design back into conformance with the ECCA. Not until much later, after a VA executive became alarmed by the contracting officer's [*28] January 2013 letter, did the VA ever express a contrary position. This reversal has no bearing on our conclusion because "[i]t is only actions and interpretations before the controversy arises, conduct during performance, that are 'highly relevant in determining what the parties intended.'" *Liles Construction Co. v. United States, 455 F.2d 527, 538-39, 197 Ct. Cl. 164 (Ct. Cl. 1972)* (quoting *Dynamics Corp. v. United States, 389 F.2d 424, 430, 182 Ct. Cl. 62 (Ct. Cl. 1968)*).

The VA now asserts in its brief that the mention of the ECCA in SA-007 "is not a material provision" and that "KT's proposal of $ 604 million for construction of the entire project had no relation to the ECCA." The agency maintains that KT is obligated to perform construction work for the FTP, altered only by the cost of scope changes and adjustments to the profit percentage pursuant to a clause contained in SA-007. The ECCA provision, according to the VA, is inconsistent with the profit adjustment clause. Further, the VA says, the ECCA was occasionally referred to as $ 604 million, rather than $ 582 million, so it was not a concrete figure. The VA also leads its brief with a statement from an electronic mail [*29] message of a KT employee warning that if the contractor makes its initial FTP proposal, it will be "commit[ting] to something we cannot build" because price reductions of nearly $ 31 million could not be achieved from subcontractors.

These contentions are not well taken. The mention of the ECCA in SA-007 is not just material to the agreement -- it is critical to the agreement. SA-007 clearly links the ECCA and the FTP, providing that the latter is dependent on the former. Altering the contract price to account for scope changes is not possible, for reasons we discuss later in this opinion. There is no inconsistency between the ECCA provision and the profit adjustment clause; if the VA had produced a design which could be constructed for the ECCA, the profit adjustment clause could have been implemented in accordance with its terms. Even if the ECCA is considered to be $ 604 million, rather than $ 582 million, as suggested by the VA, that is inconsequential; the agency never came close to providing a design that could be constructed for either amount. Any concern by a KT employee about the contractor's initial FTP proposal was overcome by events: That proposal was not accepted; an [*30] entirely different bargain was agreed to by the parties in SA-007.

(2) Did the VA materially breach the contract by failing to provide a design that could be built for the ECCA of $ 582,840,000?

As the Court of Appeals for the Federal Circuit has recognized, "Not every departure from the literal terms of a contract is sufficient to be deemed a material breach of a contract requirement." *Stone Forest Industries, Inc. v. United States, 973 F.2d 1548, 1550 (Fed. Cir. 1992)*. "A party breaches a contract when it is in material non-compliance with the terms of the contract." *Gilbert v. Department of Justice, 334 F.3d 1065, 1071 (Fed. Cir. 2003)* "A breach is material when it relates to a matter of vital importance, or goes to the essence of the contract." *Thomas v. Department of Housing & Urban Development, 124 F.3d 1439, 1442 (Fed. Cir. 1997)* (citing 5 Arthur L. Corbin, *Corbin on Contracts* § 1104 (1964)). "The standard of materiality for the purposes of deciding whether a contract was breached is necessarily imprecise and flexible. The determination depends on the nature and effect of the violation in light of how the particular [*31] contract was viewed, bargained for, entered into, and performed by the parties." *Stone Forest, 973 F.2d at 1550-51* (citing *Restatement (Second) of Contracts § 241 cmts. a & b*) (quotation omitted).

The Court and this Board have both considered the factors enunciated in *section 241 of the Restatement* when determining whether a breach is material. These factors are set out in *Lary v. United States Postal Service, 472 F.3d 1363, 1367 (Fed. Cir. 2006)*, and *Kap-Sum Properties, LLC v. General Services Administration, CBCA 2544, 2013-1 BCA P 35,446, at 173,832*:

> In determining whether a failure to render or to offer performance is material, the following circumstances are significant:
>
> (a) the extent to which the injured party will be deprived of the benefit which he reasonably expected;
>
> (b) the extent to which the injured party can be adequately compensated for the part of that benefit of which he will be deprived;
>
> (c) the extent to which the party failing to perform or to offer to perform will suffer forfeiture;
>
> (d) the likelihood that the party failing to perform or to offer to perform will cure his failure, [*32] taking account of all the circumstances including any reasonable assurances;
>
> (e) the extent to which the behavior of the party failing to perform or to offer to perform comports with standards of good faith and fair dealing.

The VA's breach of its contract with KT, by failing to provide a design which could be constructed for the ECCA, is of vital importance, as it goes to the essence of the agreement. The breach is material under each of the *Restatement* standards.

(a) KT has been deprived of the benefit of working with a design to which the project could be constructed for the ECCA. Both parties recognized that the design was not within the ECCA at the time that SA-007 was agreed to, and the

cost estimates kept escalating as time passed. Much of the blame for this situation must be ascribed to the VA; by failing to control the JVT, delaying approval of the design, presenting KT with a design which was allegedly complete but required an enormous number of modifications, failing to process change orders for approximately one year, failing to process JSIs in a timely fashion, and failing to make timely payment to KT, the agency drove up the costs of construction. The VA [*33] occasionally complained to the JVT about excessive cost, but it failed to cause the JVT design team to take actions necessary to reduce that cost. Even after convening the "blue ocean" meeting to develop ideas for significant VE cost reductions, the VA implemented few of the recommendations from the meeting and ultimately directed the JVT to abandon any efforts to include in the design many of the recommendations the agency's own staff had deemed reasonable.

(b) KT cannot be adequately compensated for the VA's failure to provide a design which could be constructed for the ECCA. As KT notes, the agency does not have sufficient funds to pay for construction of the entire project as currently designed and has no plans to ask for more money. Requiring KT to fund additional construction, without the prospect of full payment by the VA, would be manifestly unfair given the significant prospective cost. We also find that because the contract does not incorporate any particular set of drawings and specifications, determining the potential value of changes in scope is impossible. The VA's theory that the FTP stated in SA-007 was premised on the documents as they existed at the time that modification [*34] was signed is not valid. "[T]he language used in a contract to incorporate extrinsic material by reference must explicitly, or at least precisely, identify the written material being incorporated and must clearly communicate that the purpose of the reference is to incorporate the referenced material into the contract." *Northrop Grumman Information Technology, Inc. v. United States, 535 F.3d 1339, 1345 (Fed. Cir. 2008)*. No documents were included in, attached to, or incorporated by reference in SA-007. The parties cannot determine the difference between the costs of construction under an initial set of plans and the costs under a final set because no initial set of plans is specified in the contract.

(c) While the VA may suffer some forfeiture from its material breach, we find the potential forfeiture to be limited because the agency will retain possession of the land and buildings on which construction has been taking place.

(d) There is little likelihood that the VA will cure its failure, given its insistence that it will neither redesign the project nor seek additional appropriated funds to complete it.

(e) "Every contract imposes upon each party a duty of good [*35] faith and fair dealing in its performance and enforcement. Failure to fulfill that duty constitutes a breach of contract, as does failure to fulfill a duty imposed by a promise stated in the agreement. [The Court of Appeals for the Federal Circuit has] long applied those principles to contracts with the federal government." *Metcalf Construction Co. v. United States, 742 F.3d 984, 990 (Fed. Cir. 2014)* (citations and quotations omitted). The duty of good faith and fair dealing requires the Government, as well as other parties to contracts, not only to avoid actions that unreasonably cause delay or hindrance to contract performance, but also to do whatever is necessary to enable the other party to perform. *C. Sanchez & Son, Inc. v. United States, 6 F.3d 1539, 1542 (Fed. Cir. 1993)*; *Lewis-Nicholson, Inc. v. United States, 550 F.2d 26, 32, 213 Ct. Cl. 192 (Ct. Cl. 1977)*. To show a violation of the duty of good faith and fair dealing, a party need not prove that the other party to a contract acted in bad faith. *Metcalf, 742 F.3d at 993* (no specific-targeting requirement); *Sigma Services, Inc. v. Department of Housing & Urban Development, CBCA 2704, 2012-2 BCA P 35,173, at 172,591* [*36] (citing *Rivera Agredano v. United States, 70 Fed. Cl. 564, 574 n.8 (2006)*).

Applying these principles, we find that the behavior of the VA has not comported with standards of good faith and fair dealing required by law. The agency failed to provide a design that could be constructed within the ECCA because it did not control its designer, the JVT. It paid no heed to VE suggestions for cost reductions which were made by KT and Jacobs (or even those which were accepted by the agency's own medical center personnel following the "blue ocean" meeting). The agency delayed progress of construction, such as by delaying the processing of design changes and change orders, as described under factor (a) above. The agency disregarded cost estimates by KT and Jacobs, even to the point of rejecting a Jacobs estimate because it was developed under restrictions which the agency itself had imposed. The agency adopted as an independent government estimate a document which was neither independent (it

was developed by a subcontractor to the JVT, an entity which had a strong interest in the result), nor by the Government (it was by the JVT), nor an estimate (it was by admission of the [*37] chief estimator an academic exercise), and the number was so far below any previous estimate as to be of dubious accuracy. The agency did this notwithstanding the testimony of every witness who addressed the matter, including several VA witnesses, that an "independent" estimate should not be made by a party with a vested interest in the outcome. The agency ultimately directed KT to continue its construction work for the FTP, even though the agency refused to fund that work appropriately.

We do not know what the cost of construction of this project ultimately will be. It could be nearly $ 769 million (as estimated by KT in December 2013), nearly $ 785 million (as estimated by Jacobs in January 2013), more than $ 897 million (KT's firm fixed price proposal in March 2013), or $ 1.085 billion (KT's estimate in June 2013). It could even be only $ 630 million (the JVT/RLB estimate in February 2014), although that appears unlikely because this number is so much lower than all the others presented. Whether it is any of these figures, however, it will be significantly in excess of the ECCA of $ 582,840,000. We find that beyond doubt, the VA's breach of its contract with KT was material.

[*38] (3) Is KT entitled to stop work?

The Court of Appeals for the Federal Circuit has held that "[u]pon material breach of a contract the non-breaching party has the right to discontinue performance of the contract." *Stone Forest, 973 F.2d at 1550*; *see also Malone v. United States, 849 F.2d 1441, 1446 (Fed. Cir. 1988)* (holding that material breach by Government "provides Malone with a legal right to avoid the contract [and] discharges Malone's duty to perform"); *Kap-Sum Properties, 2013-1 BCA at 173,833* (citing *Malone*). The Court has explained further, "The choice of remedy is generally with the non-breaching party, and only in exceptional circumstances will equity require the non-breaching party to continue to perform the remainder of the contract." *Stone Forest, 973 F.2d at 1552*. "[I]f a contract is not clearly divisible, in accordance with the intention of the parties, the breaching party can not require the non-breaching party to continue to perform what is left of the contract." *Id.*

The VA draws our attention to *Northern Helex Co. v. United States, 455 F.2d 546, 197 Ct. Cl. 118 (Ct. Cl. 1972)*, and [*39] *Cities Service Helex, Inc. v. United States, 543 F.2d 1306, 211 Ct. Cl. 222 (Ct. Cl. 1976)*, two cases in which the Court of Claims held that if a contractor continues performance under a contract, without protest, notwithstanding the Government's breach, "the obligations of both parties remain in force and the injured party may retain only a claim for damages for partial breach." *Cities Service, 543 F.2d at 1313*. The VA's analysis, however, ignores the phrase "without protest" which is part of the teaching of these decisions. The record is clear that KT has been proceeding with the construction (to avoid any possibility of being charged with being in default) under strenuous protest, including the very constructive advancement of VE proposals, throughout the post-SA-007 history of the project. The VA also notes that in its claim, KT asked for the opportunity to suspend performance, rather than to stop performance. Whatever the contractor requested initially is not important. As a matter of law, KT has the right to stop performance.

Decision

The appeal is **GRANTED**. As enunciated in this opinion, we afford Kiewit-Turner, A Joint Venture the declaratory relief [*40] it seeks.

STEPHEN M. DANIELS

Board Judge

We concur:

HOWARD A. POLLACK
Board Judge

CANDIDA S. STEEL

Board Judge

Legal Topics:

For related research and practice materials, see the following legal topics:
Business & Corporate LawJoint VenturesGeneral OverviewContracts LawFormationExecutionPublic Contracts LawBids & FormationSubcontracts & SubcontractorsGeneral Overview

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

Question: The Office of Contract Review falls under the supervision of the Counselor to the IG, has there been any review of the Denver Medical Center contract? Since the litigation is over will IG being doing any review in the contracts going forward? Is the VA performing in accordance with construction standards and its own policies and has the IG performed a compliance review of these activities?

VA OIG Answer: The Office of Contract Review did not conduct any pre-award or post-award reviews of the contract for the Denver facility nor were any claims referred to us to audit. It is our understanding that under an agreement with VA, the Defense Contract Audit Agency conducted audit work relating to the contract.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

ACCESS TO CARE SCANDAL

Question: In response to the Phoenix Scandal the IG made 24 recommendations to the Secretary of Veterans Affairs addressing Phoenix and national health care program issues. What were these recommendations and so far how many has the VA implemented?

VA OIG Answer: As of March 30, 2015, 17 recommendations remain open from the OIG's *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, issued August 26, 2014:

A total of seven recommendations have closed since the report was issued:

- Recommendations 4, 5, and 24 closed upon report issuance.
- Recommendations 7, 14, and 17 closed on February 23, 2015.
- Recommendation 15 closed on March 12, 2015.

Although VA's next progress update on recommendation implementation was due to the OIG on March 26, 2015, VA requested an extension until April 20 to provide their documentation. The OIG approved the request but cautioned VA that all remaining unimplemented recommendations would be identified as open in the OIG's *Semiannual Report to Congress* for the period ending March 31, 2015.

A detailed list of the recommendations and the status is attached.

Attachment 2

Status of Recommendations from the OIG's Report – *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, issued August 26, 2014.

As of March 26, 2015, a total of seven recommendations have closed since the report was issued:

- Recommendations 4, 5, and 24 closed upon report issuance.
- Recommendations 7, 14, and 17 closed on February 23, 2015.
- Recommendation 15 closed on March 12, 2015.

Recommendation 1: We recommended the VA Secretary direct the Veterans Health Administration to review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients who suffered adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

Recommendation 2: We recommended the VA Secretary require the Phoenix VA Health Care System to ensure the continuity of mental health care, improve delays in assignments to a dedicated provider, and expand access to psychotherapy services.

Recommendation 3: We recommended the VA Secretary require the Phoenix VA Health Care System to reevaluate and make the appropriate changes to its method of providing veterans primary care to ensure they provide veterans timely and quality access to care.

Recommendation 4: We recommended the VA Secretary direct the Veterans Health Administration to establish a process that requires facility directors to notify, through their chain of command, the Under Secretary of Health when their facility cannot meet access or quality of care standards. **[Closed]**

Recommendation 5: We recommended the VA Secretary review all existing wait lists at the Phoenix VA Health Care System to identify veterans who may be at risk because of a delay in the delivery of health care and provide the appropriate medical care. We provided this recommendation to the former VA Secretary in the *Interim Report*. **[Closed]**

Recommendation 6: We recommended the VA Secretary take immediate action to ensure the Phoenix VA Health Care System reviews and provides appropriate health care to all veterans identified as being on unofficial wait lists. We provided this recommendation to the former VA Secretary in the *Interim Report*.

Recommendation 7: We recommended the VA Secretary ensure all new enrollees seeking care at the Phoenix VA Health Care System receive an appointment within the time frames directed by VHA policy. **[Closed]**

Recommendation 8: We recommended the VA Secretary ensure the Phoenix VA Health Care System timely process enrollment applications.

Recommendation 9: We recommended the VA Secretary ensure the Phoenix VA Health Care System follows VA consultation guidance and appropriately reviews consultations prior to closing them to ensure veterans receive necessary medical care.

Recommendation 10: We recommended the VA Secretary ensure the Phoenix VA Health Care System staff timely verify and record veteran deaths in the Veterans Health Information Systems and Technology Architecture.

Recommendation 11: We recommended the VA Secretary ensure the Phoenix VA Health Care System establish an internal mechanism to perform routine quality assurance reviews of scheduling accuracy.

Recommendation 12: We recommended the VA Secretary ensure all Phoenix VA Health Care System staff with scheduling privileges satisfactorily complete the mandatory Veterans Health Administration scheduler training.

Recommendation 13: We recommended that upon the completion of the investigation the VA Secretary confer with appropriate VA staff and determine whether administrative action should be taken against management officials at the Phoenix VA Health Care System and ensure that action is taken where appropriate.

Recommendation 14: We recommended the VA Secretary ensure Phoenix VA Health Care System include an employee satisfaction measure and a veteran satisfaction measure in Phoenix VA Health Care System management's performance plans and facility goals. **[Closed]**

Recommendation 15: We recommended the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition. We provided this recommendation to the former VA Secretary in the *Interim Report*. **[Closed]**

Recommendation 16: We recommended the VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility's Electronic Wait List. We provided this recommendation to the former VA Secretary in the *Interim Report.*

Recommendation 17: We recommended the VA Secretary establish veteran-centric goals and eliminate current goals that divert focus away from providing timely quality care to all eligible veterans. **[Closed]**

Recommendation 18: We recommended the VA Secretary take measures to ensure use of "desired date" is appropriately applied.

Recommendation 19: We recommended the VA Secretary provide veterans needed care in a timely manner and minimize the use of the Electronic Wait Lists.

Recommendation 20: We recommended the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.

Recommendation 21: We recommended the VA Secretary initiate a process to selectively monitor calls from veterans to schedulers and then incorporate lessons learned into training or performance plans.

Recommendation 22: We recommended the VA Secretary conduct a review of the Veterans Health Administration's Ethics Program to ensure the Program's operational effectiveness, integrity, and accountability.

Recommendation 23: We recommended the VA Secretary initiate actions to update the Veterans Health Administration's current electronic scheduling system and ensure milestones and costs are monitored.

Recommendation 24: We recommended the VA Secretary ensure that the Veterans Health Administration establishes a mechanism to ensure data representing VA's national performance are validated by an internal group that has direct access to the Under Secretary for Health. **[Closed]**

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

Question: What monitoring is being done now to make sure this issue is being dealt with by the VA? Are you monitoring the implementation of the Veterans Choice Program and if so are there any problems that have been observed?

VA OIG Answer: *The Veterans Access, Choice and Accountability Act* (VACAA) requires the OIG to audit the accuracy and timeliness of payments made under this law within 30 days after VHA has spent 75 percent of the $9.7 billion in funding authorized for patient care by the VACAA. Although VA has obligated approximately $394 million to pay for Choice Card medical services, as of March 1, 2015, VA has not processed any claims for medical services. Once VA has made a sufficient number of claim payments, we will start to audit the accuracy and timeliness of payments.

[Questions for the Record submitted by Congressman Bishop for the Deputy Inspector General Richard J. Griffin follows:]

MEDICAL CARE COLLECTION FUND

Question: Since 2002, the VA/OIG has released at least three reports on billings and collections associated with the VA's Medical Care Collection Fund (MCCF). I believe that the last report was released in 2012. As you know, while billings for non-service-connected healthcare have increased over the past few years, collections have remained relatively flat. Every dollar that is not collected is one less dollar that could be used for veterans' health programs.

Question: Is your office conducting another audit of the MCCF? If so, when can we expect it? If not, what would it take for the OIG to conduct another audit, since problems in this area continue? How has the VA implemented your recommendations/suggestions, especially those in the 2011 and 2012 reports? Does the OIG have any responsibilities in overseeing the implementation of the 2014 Veterans Access Act?

VA OIG Answer: At the present time we are not conducting an audit of VA's Medical Care Collection Fund (MCCF). However, we have initiated a program risk assessment that is focusing on insurance verification and medical coding. We have closed the five recommendations made in our May 2011 report (*Audit of the Medical Care Collection Fund Billings for Non-VA Care*, May 25, 2011) on MCCF billings for non-VA care, and the four recommendations made in our August 2012 report (*Audit of VHA's Medical Care Collections Fund Billing of VA-Provided Care*, August 30, 2012). Depending on the results of our program risk assessment, we may include an audit of MCCF in our FY 2016 operations plan. VACAA does not assign the OIG with any responsibilities to provide oversight of MCCF. However, VACAA does require the OIG to audit the accuracy and timeliness of payments made under this law within 30 days after VHA has spent 75 percent of the $9.7 billion in funding authorized for patient care by the VACAA.